

State Insurance Benefits Options for Retirees



2003

Employee Insurance Program

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Contents

Introduction	1
Retiree Insurance Eligibility	2
Local Subdivisions	2
TERI Participants	2
Eligibility for Employer-Funded Insurance	2
Eligibility for Non-Employer-Funded Insurance	2
Eligibility for Survivors	3
COBRA Eligibility	4
Choosing a Health Plan in Retirement	5
Your Health Plan Choices	5
Making a Decision	6
Health Plans Available in South Carolina, By Service Area	6
Enrollment and Making Changes to Coverage	8
Enrollment	8
Late Entrant	8
TERI Participants	8
COBRA	8
When Your Coverage as a Retiree Begins	9
Retiree Premiums/Premium Payment	9
Your Insurance Identification Card in Retirement	9
Special Eligibility Situations	10
Changes You May Make Throughout the Year	10
Terminating Or Cancelling Coverage	11
When You Or Your Dependents Become Entitled to Medicare	12
About Medicare	12
Where To Go for More Information Regarding Medicare	12
At Age 65	12
Disability	13
Sign up for Medicare!	13
Your Plan Choices	13
TRICARE	13
How Medicare Assignment Works	13
How the State Health Plan's Standard Plan Works Together With Medicare	14

How the Medicare Supplemental Plan Works Together With Medicare	15
How the HMO and POS Plans Work Together With Medicare	16
Tips on Choosing a Plan	18
The State Health Plan in Retirement	19
General Information Regarding the Standard and Economy Plans	19
Deductibles and Coinsurance	19
Medicare and the SHP Hospital Network	20
Medicare and the SHP Physician Network	20
Using Medi-Call as a Retiree	20
Mental Health and Substance Abuse: Using APS As a Retiree	21
Prescription Drug Program	21
Medicare and the Ambulatory Surgical Center Network	21
Medicare and Transplant Contracting Arrangements	21
Mammography Testing Benefit	22
Pap Test Benefit	22
Maternity Management Benefit and Well Child Care Benefit	22
Filing Claims As a Retiree	22
The Medicare Supplemental Plan	24
General information	24
Medicare Deductibles and Coinsurance	24
Medicare Supplemental Plan Deductibles and Coinsurance	24
What the Medicare Supplemental Plan Covers	24
Medicare and the SHP Hospital Network	26
Medicare and Using Medi-Call	26
Mental Health and Substance Abuse: When to Call APS	27
Medicare and the Ambulatory Surgical Center Network	27
Medicare and Transplant Contracting Arrangements	27
Mammography Testing Benefit	27
Pap Test Benefit	27
Maternity Management Benefit and Well Child Care Benefit	27
Filing Claims As a Retiree	28
HMO and POS Plans in Retirement.....	29
Availability	29
Provider Networks.....	29
Prescription Drug Programs	29
Filing Claims As a Retiree.....	30

Comparison of Health Plan Benefits for Retirees and Dependents NOT Entitled to Medicare	32
Comparison of Health Plan Benefits for Retirees and Dependents Entitled to Medicare	36
Your Dental Benefits in Retirement	40
State Dental Plan	40
State Dental Plan Covered Services	40
To Continue Coverage in Retirement	41
Predetermine Your Benefits for Expensive Treatment	41
Filing Dental Claims	41
Dental Plus	42
Filing Dental Plus Claims	42
Life Insurance in Retirement	43
\$3,000 Basic Life Insurance	43
South Carolina Retirement Systems Retiree Group Life Insurance	43
Optional Life Insurance	43
Dependent Life Insurance	44
Retirement and Long Term Disability Benefits	45
Basic Long Term Disability	45
Supplemental Long Term Disability	45
Long Term Care in Retirement	46
Determine Your Need for Long Term Care Insurance	46
Long Term Care Services Already Covered	46
Advantages of the Long Term Care Program	46
When Long Term Care Pays	46
What Long Term Care Pays	46
What Long Term Care Does Not Pay	47
Continuing Coverage Into Retirement	47
Enrolling in Coverage at Retirement	47
Premiums in Retirement	47
MoneyPlu\$ Not Available in Retirement	48
Vision Care Program in Retirement	48
Returning to Work	49
Deciding on Coverage	49
If You Are Entitled to Medicare	49
TERI Program	49
How TERI Works	49

How TERI Affects Your Insurance Coverage	50
Retiree Outreach Services	50
2003 Regular Retiree (Employer-Funded Benefits) Dental Plan Monthly Premiums	51
2003 Regular Retiree (Employer-Funded Benefits) Health Plan Monthly Premiums1 ...	51
2003 Retiree (5-10 year, buy-in & age 55/25 year) Dental Plan Monthly Premiums	52
2003 Retiree (5-10 year, buy-in & age 55/25 year) Health Plan Monthly Premiums	52
2003 Survivor Dental Plan Monthly Premiums.....	53
2003 Survivor Health Plan Monthly Premiums1	53
2003 COBRA Dental Plan Monthly Premiums	54
2003 COBRA Health Plan Monthly Premiums	54
2003 Optional Life Insurance Premiums	55
2003 Long Term Care Insurance Premiums (Continuing Coverage From Active Employment Into Retirement)	56
2003 Long Term Care Insurance Premiums (Enrolling in Coverage at Retirement if Not Covered During Employment)	57
Who to Contact for More Information	58
Glossary of Terms	G-1
Index	I-1

Introduction

This book is for prospective retirees and retired employees of participating state insurance program entities who are retiring or have retired on service, age, approved disability retirement through the South Carolina Retirement Systems (SCRS) or approved for Basic Long Term Disability and/or Supplemental Long Term Disability. It is designed to provide you with helpful information for making insurance coverage decisions throughout your retirement. Please review this book and discuss your benefit choices with family members prior to making decisions.

More detailed information regarding the various benefits programs may be found in the *Insurance Benefits Guide*, which is available from your employer or from the Employee Insurance Program (EIP). Please contact EIP if you have any questions or need additional information. You may visit our Web site at www.eip.state.sc.us or call us at 803-734-0678 (toll-free at 1-888-260-9430).

The summary of benefits in this handbook does not represent an employee/employer contract. Program provisions are subject to change. This information is designed to assist you in making insurance coverage decisions. Please consult your *Insurance Benefits Guide* and information and literature from the various HMOs offered in your service area. The *Plan of Benefits Document* and the state basic dental fee schedule are available from your benefits office or the Employee Insurance Program for specific contractual questions.

Retiree Insurance Eligibility

The eligibility rules that follow are used to determine if retirees from employers that participate in the state insurance program are eligible for insurance coverage after retirement. These rules apply to retirees who meet one or more of the rules below and who retire:

- Due to years of service with the state;
- Due to age;
- On approved disability through the South Carolina Retirement Systems (SCRS);
- On approved Basic Long Term Disability and/or Supplemental Long Term Disability.

Local Subdivisions

Please note that each local subdivision sets its own guidelines for funding retirees. Local subdivision employees should contact their benefits office for information concerning retiree insurance premiums.

TERI Participants

If you are a Teacher and Employee Retention Incentive (TERI) participant, you are retired for retirement benefit purposes only. Therefore, if you are a TERI program participant in a permanent, full-time position, your insurance benefits as an active employee should continue until your TERI period ends or you become ineligible as an active employee. When your active insurance benefits end, you should file for continuation as a retiree (if eligible) within 31 days of termination. If you are not eligible for insurance as a retiree, you may be eligible for continuation under COBRA.

Eligibility for Employer-Funded Insurance

(State Pays the Employer Share of the Premiums)

To be eligible to receive employer-funded insurance benefits in retirement, you must meet one of the following criteria:

- You must be eligible to retire when you leave active employment and have 10 or more years of retirement service credit with a participating state insurance program employer.*
- If you leave employment before you are eligible to retire, you must have 20 or more years of service credit with an employer that participates in the state insurance program.*
- If you left employment prior to 1990 and were not of retirement age at that time, but you had 18 years of service credit with an employer that participates in the state insurance program and then returned to work with a state-covered employer, enrolled in a state health and dental plan, you must work for at least two consecutive years in a full-time, permanent position.

** The last five years must be consecutive and in a full-time, permanent position with an employer that participates in the state insurance program.*

Eligibility for Non-Employer-Funded Insurance

(Retiree Pays Both the Employer and Retiree Shares of the Premiums)

If you are not eligible for employer-funded insurance, then to be eligible to receive *non-employer-*

funded insurance benefits in retirement, you must meet one of the following criteria:

- You retire at age 55 through 59 with at least 25 years of retirement service credit, including at least 10 years with an employer that participates in the state insurance program.* Although sick leave may increase service credit under SCRS, it does not count toward insurance eligibility. You pay the full insurance premium until you reach age 60 or the date you would have had 28 years of service credit, whichever occurs first. At the end of this period, you will be eligible for the employer-funded retiree rates. Retirees must pay the entire premium until age 60 or until they reach the date they would have had 28 years of service credit if they had continued working. (This rule does not apply to Police Officers Retirement System, General Assembly Retirement System and Judges-Solicitors Retirement System participants.)
- You retire with at least five but fewer than 10 years of retirement service credit with a participating state insurance program employer.*
- If you are a General Assembly member and leave employment before you are eligible to retire, you must have eight years of General Assembly Retirement System (GARS) service credit. The eight years must be with the GARS, but may include any credited service (military, non-member, federal, etc.).
- If you are a former municipal or county council member who served on the council for at least 12 years and were covered under the state's plans when you left the council, the county or municipal council decides whether to allow you to have this coverage.
- You are a "buy-in" retiree with at least 10 years of retirement service credit with a participating state insurance program employer, and you established your "buy-in" service credit prior to January 1, 2001.* You must pay the full insurance premium for the "buy-in" period or until age 60, whichever occurs first. At the end of this period, you will be eligible for the employer-funded retiree rates.
Please note: If you refuse insurance coverage during your "buy-in" period, you must enroll within 31 days of the end of the "buy-in" period; otherwise you may enroll as a late entrant or within 31 days of a special eligibility situation. If you enroll as a late entrant, you would then pay the full premium for the remainder of the "buy-in" period or until you reach age 60, whichever occurs first. Afterward, you would be eligible for employer-funded retiree rates. This rule does not apply to the "non-qualified" service purchase.

** The last five years must be consecutive and in a full-time, permanent position with an employer that participates in the state insurance program.*

Eligibility for Survivors

The health insurance premium for surviving covered spouses and dependents of deceased employees or employer-funded retirees will be waived for one year after the active or retired employee's death (if the deceased's last employer was a local subdivision employer, check with that employer to see whether this waiver applies). After the first-year premium waiver ends, a surviving spouse and/or dependent child of a deceased state employee/retiree may continue coverage by paying the full insurance premium. If the deceased's health insurance premium is not employer-funded, the surviving spouse and/or dependents may continue coverage by paying the full insurance premium from the date of death. Survivors must contact the Employee Insurance Program to enroll. Coverage is not automatic. However, if the surviving spouse and/or the surviving dependents are covered at the time of death of the retiree, coverage will be continued automatically.

Surviving spouses may remain covered, provided premiums are paid, until remarriage. Remarriage at any time will terminate eligibility for this coverage. Children cease to be eligible for coverage when they become age 19; marry; or begin full-time, permanent employment, whichever occurs first. Unmarried, surviving children who are 19 years of age but under age 25 may continue coverage if enrolled as full-time students (documentation required). Incapacitated children may continue coverage beyond the age requirements (medical documentation required).

COBRA Eligibility

Any covered subscriber who loses coverage and does not meet any of these rules may still be eligible for coverage continuation under COBRA. If you are not eligible for retiree health insurance, you must request continuation coverage as provided by the *Consolidated Omnibus Budget Reconciliation Act* (COBRA) of 1985 within 60 days of loss of coverage or COBRA notification due to a qualifying event, whichever is later.

Choosing a Health Plan in Retirement

Your Health Plan Choices

Not Entitled to Medicare

If you and your covered dependents are not entitled to Medicare, you may choose to be covered under one of the following:

- The State Health Plan Economy plan;
- The State Health Plan Standard plan;
- A health maintenance organization (HMO) offered in your service area (See Page 6 for service areas);
- An HMO with a Point of Service (POS) option offered in your service area (See Page 6 for service areas).

Your benefits will be the same as if you were an active employee.

Entitled to Medicare

If you and/or your covered dependents are entitled to Medicare, you may choose to be covered under one of the plans listed below. Refer to the section, “When You or Your Dependents Become Entitled to Medicare,” for explanations of how these plans coordinate benefits with Medicare.

- The State Health Plan Standard plan;
- The State Health Plan Medicare Supplemental plan;
- An HMO offered in your service area (See Page 6 for service areas);
- A POS plan offered in your service area (MUSC Options not available) (See Page 6 for service areas).

Note: If you and/or your covered dependents are entitled to Medicare, the State Health Plan Economy plan and MUSC Options are not available.

When you become entitled to Medicare, Medicare becomes the primary carrier (some exceptions apply; contact the Social Security Administration for more information), and your retiree insurance coverage becomes secondary. **It is important you enroll in Medicare Part A and Part B to receive your maximum benefits, because your secondary carrier will process your claims as if you have both parts of Medicare.**

If you enroll in the Medicare Supplemental Plan, benefits for other covered persons who are *not* entitled to Medicare will be paid on the basis of the Standard plan.

Health Plans Available in South Carolina, By Service Area

AREA	COUNTY	HEALTH PLAN CHOICES
1	Anderson, Greenville, Oconee, Pickens	State Health Plan, Companion-Choices, CIGNA POS
2	Cherokee, Spartanburg, Union	State Health Plan, Companion-Choices, CIGNA HMO
3	Chester, Lancaster, York	State Health Plan, Companion HMO, CIGNA HMO
4	Abbeville, Greenwood, Laurens, McCormick, Saluda	State Health Plan, Companion HMO
5	Fairfield, Kershaw, Lexington, Newberry, Richland	State Health Plan, Companion HMO, CIGNA POS
6	Aiken, Barnwell, Edgefield	State Health Plan, Companion HMO
7	Allendale, Bamberg, Calhoun, Orangeburg	State Health Plan, Companion HMO, CIGNA HMO
8	Clarendon, Lee, Sumter	State Health Plan, Companion HMO, CIGNA HMO
9	Chesterfield, Darlington, Dillon, Florence, Marion, Marlboro, Williamsburg	State Health Plan, Companion HMO, CIGNA HMO
10	Georgetown, Horry	State Health Plan, Companion HMO, CIGNA HMO
11	Berkeley, Charleston, Colleton, Dorchester	State Health Plan, Companion HMO, CIGNA HMO, MUSC Options*
12	Beaufort, Hampton, Jasper	State Health Plan, Companion HMO, CIGNA HMO

**MUSC Options is not available if you or your covered dependents are entitled to Medicare.*

Making a Decision

Choosing a health plan requires thought and planning. Costs, services provided, benefits offered and provider networks are all major factors to consider when making a health plan decision. Although no plan will cover all of your medical care costs, there are plans that are better suited for you and your family's health care needs than others.

You cannot predict exactly what your health care needs will be for the coming year, but you can anticipate to some extent what services you and your family might need. By taking the time to decide what benefits and services are important to you and your family and comparing the available plans, you'll be able to choose a health plan that is right for you.

What Benefits Are Offered?

Although most plans provide basic health coverage, the details are what count. When choosing a plan, you may want to find out how it covers the following services:

- Specialist care;
- Emergency room visits and hospitalizations;
- Prescription drugs;
- Mental health and substance abuse services;
- Obstetrical-gynecological care and well child care visits;
- Physical exams;
- Health screenings and preventive care;
- Nursing home, home health and hospice care;
- Physical therapy and other rehabilitative care;
- Vision care;
- Chiropractic or alternative health care;
- Medical services outside the designated service area or provider network.

What Is Important To Me?

Before choosing a health plan, decide what is most important to you. You may want to consider:

- How you feel about a primary care physician making referrals for you;
- Whether freedom to choose which doctor or hospital to use is important to you;
- How much you can pay in premiums and deductibles and other patient cost sharing;
- Whether the plan offers benefits that meet your needs. Do you or a member of your family have a chronic condition or disability? How does the plan provide coverage for family members who travel out of the service area, state or country?
- If you and/or a covered family member are entitled to Medicare, be sure you have Medicare Part B when you are covered under the retiree group insurance program; compare the State Health Plan Standard plan to the Medicare Supplemental plan.

How Do I Compare Plans?

When comparing the available health plans, look at the services each plan covers. Are there services that are limited or not covered (exclusions)? Which doctors, hospitals and other providers participate in the plan's networks (i.e., Does your doctor participate)? Are the doctors accepting new patients? Do you need approval from the plan or primary care physician before going to the hospital or receiving specialty care? Finally, compare the costs. Consider things such as deductibles, copayments, how much the plan will pay once your deductible has been met, how much the plan will pay if you use a non-participating provider and the limits on how much the plan will pay in a year or over a lifetime. Charts comparing some of the benefits among these plans are on Pages 32-39.

Enrollment and Making Changes to Coverage

Enrollment

Eligible retirees must enroll by filing a Retiree Notice of Election within 31 days of their retirement date or within 31 days of approval for disability retirement or Long Term Disability benefits or within 31 days of a special eligibility situation (see “Special Eligibility Situations” on Page 10). **Coverage is not automatic.** You may enroll yourself and any eligible dependents. Those enrolling who have had a break in health coverage for more than 62 days will be subject to pre-existing condition exclusions for 12 months.

Late Entrant

If you and /or your dependents do not enroll within 31 days of retirement, disability approval or a special eligibility situation, you may enroll during an open enrollment period held every odd year (October 2003, for example) as a late entrant. Your coverage will take effect the following January 1 (January 1, 2004, for example), but, as a late entrant, your coverage will be subject to a pre-existing condition exclusion for 18 months after coverage begins.

TERI Participants

If you are a Teacher and Employee Retention Incentive (TERI) participant, you are retired for retirement benefit purposes only. Therefore, if you are a TERI program participant in a permanent, full-time position, your insurance benefits as an active employee should continue until your TERI period ends or until you become ineligible as an active employee. When your active insurance benefits end, you should file for continuation as a retiree (if eligible) within 31 days of termination. If you are not eligible for insurance as a retiree, you may be eligible for continuation under COBRA.

COBRA

If you are not eligible for retiree health insurance, you may request continuation coverage, as provided by the *Consolidated Omnibus Budget Reconciliation Act* (COBRA) of 1985, within 60 days of loss of coverage or COBRA notification due to a qualifying event, whichever is later.

Covering Dependents

Keep these points in mind when covering dependents:

- Each eligible dependent must be listed on your Notice of Election (NOE) form to have health and/or dental coverage. **Don't forget to include their Social Security numbers!**
- Dependents may include your spouse—if your spouse is not an employee or retiree of a state-covered entity—as well as children through age 18 (natural, adopted, foster and those for whom you have legal custody).
- A dependent child age 19 through 24 may continue coverage under your plan if that child is a full-time student. You must verify the full-time student status within 31 days of the date the child turns age 19. If you fail to certify your dependent child as a student within 31 days of the dependent's 19th birthday or within 31 days of enrollment, the child will become ineligible for claims payment. Remember to notify the Employee Insurance Program (EIP) if the student drops out of school, graduates

prior to age 25, marries or gains employment with benefits.

- A dependent child age 19 and older may be covered by your plan if that child is incapacitated. The incapacitation must have developed or begun to develop before the child turned 19 (or before age 25 if the child was certified as a full-time student). You must provide evidence of incapacitation within 31 days of the child's 19th or 25th birthday. In addition, if your dependent becomes entitled to Medicare, please notify EIP immediately.

When Your Coverage as a Retiree Begins

If you go directly from active employment into retirement, retiree coverage will begin on your retirement date if you retire on the first of the month. Otherwise, retiree coverage will begin the first of the month following your retirement date; in the interim, your coverage as an active employee, if applicable, remains in effect.

Retiree Premiums/Premium Payment

State Agency and School District Retirees

Your health, dental, Dental Plus and Long Term Care premiums are deducted from your South Carolina Retirement Systems monthly retirement check. If the total premiums exceed the amount of your check, EIP will bill you directly for the full amount, or you may request a bank draft.

Local Subdivision Retirees

(retirees of counties, municipalities, regional tourism promotion commissions, county disability and special needs boards, regional councils of government, regional transportation authorities, alcohol and other drug abuse planning agencies, health care centers, special purpose districts created by the General Assembly to provide gas, water or sewer service or any combination of such services; recreation districts; hospital districts; councils on aging and community action agencies)

You pay your health, dental, Dental Plus and Long Term Care premiums directly to your former employer. That employer decides whether you must pay all or any portion of the employer share of the premiums. Contact your benefits office for information concerning your insurance premiums at retirement.

Your Insurance Identification Card in Retirement

Keep your identification card if you do not change plans when you retire. You and your covered dependents will not receive new identification cards at retirement if you remain under any State Health Plan option and the State Dental Plan. You will receive a new health identification card if you are changing from an HMO to any State Health Plan option or vice versa. If your card is lost, stolen or damaged, you may request a new card from EIP or directly from the following:

- | | |
|---------------------|---|
| • State Health Plan | BlueCross BlueShield of South Carolina; |
| • HMO/POS | CIGNA HealthCare, Companion HealthCare or MUSC Options; |
| • Dental Plus | Harrington Benefit Services, Inc. |

Almost all insurance plans use some form of your Social Security number as your identification. For example, the State Health Plan uses your Social Security number, but also includes the letters, "ZCS" in front of the number to identify you as a subscriber of the State Health Plan's Economy, Standard, or Medicare Supplemental plan.

Special Eligibility Situations

Coverage changes allowed due to a special eligibility situation must be made within 31 days of the date of occurrence. The coverage change must be consistent with the special eligibility situation. Special eligibility situations include:

- Retirement;
- Entitlement to Medicare;
- Marriage;
- Birth, adoption or placement;
- Divorce or legal separation;
- Gaining other coverage;
- Involuntary loss of other coverage;
- Spouse becomes a state employee;
- Spouse loses or gains employment;
- Spouse retires;
- Child turns age 19 and is not a full-time student;
- Child age 19 through 24 becomes a full-time student;
- Child is a full-time student who turns age 25;
- Child becomes incapacitated prior to age 19 or prior to age 25 if a full-time student;
- Death of a covered dependent;
- Child marries or gains employment with benefits.

Changes You May Make Throughout the Year

Adding/Changing Coverage

- You may enroll yourself and any eligible dependents in a health and/or dental plan within 31 days of a special eligibility situation (see above). Documentation of involuntary loss of other coverage is required, and you may enroll only those persons for whom the loss of coverage applies. You must file an NOE and documentation within 31 days of the event. Changes not made within 31 days of the special eligibility situation may not be made until the next open enrollment period or special eligibility situation.
- You may enroll yourself and/or your spouse in the Long Term Care (LTC) Insurance Plan or increase your coverage level with approval of medical evidence of good health. For more information, contact EIP or Aetna, administrator of the LTC program.
- Enrollees and their covered dependents may change to or from the Medicare Supplemental plan within 31 days of entitlement to Medicare. If you or a covered dependent turns age 65 and becomes entitled to Medicare, EIP will contact you in advance to ensure proper enrollment in the plan of your choice and to correct premium adjustments. **If you or a covered dependent becomes entitled to Medicare prior to age 65 (for example, because of a disability), you must notify EIP within 31 days of Medicare entitlement for proper enrollment and premium adjustments.**

Decreasing Coverage

You may decrease your coverage level for health and dental if a spouse or dependent child becomes ineligible (spousal divorce or separation, child turns age 19 and is no longer a full-time student, child turns age 25, child marries or becomes employed with benefits). Changes should be requested within 31 days of ineligibility.

Terminating Or Cancelling Coverage

Your health and/or dental insurance coverage may be terminated/cancelled only upon the following:

- Your written request and/or if dropping dependents within 31 days of gaining other coverage. If changes are not made within 31 days of gaining other coverage, coverage may not be dropped until the next open enrollment period.
- Written request from a family member who has power of attorney.
- Nonpayment of premiums.

When You Or Your Dependents Become Entitled to Medicare

About Medicare

Medicare has two parts—*Part A* and *Part B*. Part A is your hospital insurance. Most people do not pay a premium for Part A, because they or their spouse paid Medicare taxes while working. Part A helps cover your inpatient care in hospitals, critical access hospitals in rural areas and skilled nursing facilities. It also covers hospice care and some home health care. You must meet certain conditions to be eligible for Part A; refer to Medicare for additional information.

Medicare Part B is your medical insurance. Most people do pay a premium through the Social Security Administration for Part B. It helps cover doctors' services and outpatient hospital care. It also covers some other medical services that Part A does not cover, such as some of the services of physical and occupational therapists and home health care. Part B pays for these covered services and supplies when they are medically necessary.

Medicare guarantees you coverage, regardless of health, if you are eligible. There are no pre-existing conditions.

The Medicare + Choice program was created by the *Balanced Budget Act* of 1997. Individuals may now choose from a number of new health plan options in addition to Part A and Part B under the original Medicare program. Types of plans available, depending upon availability in your area, may include health maintenance organizations (HMOs), HMOs with Point of Service options, preferred provider organizations, provider sponsored organizations, etc. You must have Medicare Part A and Part B to join a Medicare + Choice plan. These additional plan options are not addressed in this publication. Call Medicare or visit the Medicare Web site (see below) for additional information.

Where To Go for More Information Regarding Medicare

To find out more about Medicare:

- Visit the Medicare Web site at www.medicare.gov;
- Call 1-800-MEDICARE (1-877-486-2048 TTY).

At Age 65

You should be notified of Medicare entitlement by the Social Security Administration three months in advance of reaching age 65 or at the time of entitlement due to disability. If not, contact your local Social Security office. If you are already receiving Social Security benefits when you turn 65, Medicare Part A and Part B start automatically. If you're not receiving Social Security, you should sign up for Medicare close to your 65th birthday, even if you aren't ready to retire.

If You Are an Active Employee

If you're actively working, you do not need to sign up for Part B because your insurance as an active employee remains primary while you are actively working. Keep in mind that when you subsequently

retire you should sign up for Part B within 31 days of your retirement as Medicare becomes your primary coverage in retirement.

If You Are a Retiree

If you are entitled to Medicare due to reaching age 65, the Employee Insurance Program (EIP) will notify you three months in advance of your 65th birthday so you may decide whether to change to the Medicare Supplemental plan, retain the Standard plan or retain one of the health maintenance organizations available in your service area. How these plans coordinate their benefits with Medicare is explained, beginning on Page 14.

Disability

If you are entitled to Medicare due to disability before age 65, **you must notify EIP within 31 days of Medicare entitlement** to be advised of your options and to receive coordination of benefits with Medicare. Should you become entitled to Medicare prior to age 65, you are advised to notify EIP immediately.

Sign up for Medicare!

You must enroll in both Part A and Part B of Medicare to receive full benefits with any state-offered retiree group health plan. You should enroll in Medicare Part B if you are covered through the retiree group since these plans will coordinate with Part B benefits regardless of your Medicare status.

Your Plan Choices

When you and/or your eligible dependents are covered under retiree group health insurance and become entitled to Medicare, Medicare becomes the primary payer, and your options change. The state offers you and your eligible dependents a choice between two State Health Plan (SHP) options—the *Standard* plan or the *Medicare Supplemental* plan. *If you choose the Medicare Supplemental plan, the person(s) without Medicare will have claims paid through the Standard plan's provisions.* (The Economy plan is no longer available to you. If you are enrolled in the Economy plan and you do not select another available plan, your coverage will change automatically to the Standard plan, which uses the carve-out method of claims payment with Medicare, described later in this section.)

If you prefer, you may, instead, select a health maintenance organization (HMO) or an HMO with a Point of Service (POS) option, if available in your area, to meet a variety of health care needs (a list of those offered and their service areas is on Page 6). Contact the HMO for information.

TRICARE

If you are a military retiree or an eligible spouse or dependent of a military retiree and you have Medicare Part B, you should also be entitled to TRICARE. TRICARE acts as a supplemental insurance to Medicare. If you have other insurance such as the SHP, TRICARE will be the third payer after Medicare and the SHP. Please review your benefits under TRICARE versus the SHP. For more information call TRICARE at 1-888-343-5433. If you have TRICARE and wish to drop your SHP coverage, you should notify EIP to request a Notice of Election (NOE) form or submit a written request of cancellation.

How Medicare Assignment Works

Under Medicare assignment, the Medicare subscriber agrees to have Medicare's share of the cost of

services paid directly (“assigned”) to a provider. Participating providers have agreed to submit all their Medicare claims on an assigned basis. Non-participating providers may choose whether to accept assignment on each individual claim. If you receive services from a non-participating physician, ask if he will accept assignment.

Doctors and suppliers have the opportunity each year to participate in the Medicare program. This means that participants will always accept the Medicare-approved amount as payment in full. Some doctors choose to accept assignment, some do not. If a doctor does not accept assignment, you may end up paying more for his or her services.

If a doctor decides to participate, the contract is good all year (the doctor cannot decide in the middle of the year to no longer participate). Independent laboratories and doctors who perform diagnostic laboratory services and non-physician practitioners must accept assignment.

How the State Health Plan’s Standard Plan Works Together With Medicare

“Carve-out” Method of Claims Payment

The Standard plan coordinates with Medicare on the basis of the SHP-approved charge. The carve-out method of claims payment works just like coordination of benefits with any other plan when an individual is covered by two insurance plans—one pays first and the other pays second. If your provider accepts Medicare assignment, the Standard plan will pay the lesser of:

1. The Medicare-allowed amount less the Medicare-reported payment; or
2. The SHP-allowed amount less the Medicare-reported payment.

If your provider does not accept Medicare assignment, the Standard plan pays the difference between the SHP’s allowable amount and the amount Medicare reported paying.

If the Medicare payment exceeds the SHP’s allowable amount, the Standard plan will not pay a benefit. The Standard plan will never pay charges that are more than the SHP’s allowable amount.

With the Standard plan, your total benefits (Medicare plus the SHP) will be equivalent to those offered to active employees and retirees not entitled to Medicare.

Example:

Hospital bill for a January admission is \$7,500:

\$7,500	Hospital bill
- 840	Medicare Part A deductible for 2003
\$6,660	Medicare payment
\$ 840	You pay (unless you have another health insurance plan)

If services are provided in South Carolina, the claim will be sent automatically to the SHP. If services are provided outside South Carolina, you will need to send the Explanation of Medicare Benefits

(EOMB) to BlueCross BlueShield of South Carolina. If the claim is for mental health or substance abuse services, whether provided inside or outside South Carolina, you will need to send the EOMB to APS Healthcare, Inc. Provider addresses are located on Pages 58-59.

If you are enrolled in the Standard plan your claim will be processed like this:

\$7,500	Hospital bill
- 250	Standard plan deductible for 2003
7,250	Standard plan liability
x 80%	Standard plan coinsurance
\$5,800	Amount the plan would pay in the absence of Medicare
- 6,660	Amount paid by Medicare
\$ -0-	Standard plan pays nothing, you pay 20 percent or balance of bill*

**You pay the 20 percent coinsurance or the balance of bill, whichever is less. In this example, your 20 percent coinsurance of \$1,450, plus the \$250 deductible, is \$1,700; however, the balance of the bill is only \$840, so you pay \$840. Once you reach your \$1,500 coinsurance maximum, all claims will be allowed at 100 percent of the allowable charge based on the carve-out method of claims payment. All Medicare deductibles and Medicare Part B 20 percent coinsurance should be paid-in-full for the rest of the calendar year after you reach your \$1,500 coinsurance maximum.*

Additional information about the SHP Standard Plan is provided in the section “The Standard Plan in Retirement” and in your *Insurance Benefits Guide*.

How the Medicare Supplemental Plan Works Together With Medicare Deductibles and Coinsurance

The Medicare Supplemental plan pays only Medicare-approved charges. It supplements Medicare by paying the Medicare Part A (hospital) and Part B (medical) deductibles in full. The plan will also pay the 20 percent coinsurance after Medicare pays 80 percent for Part B-approved services.

The Medicare Supplemental plan pays the coinsurance days for hospitalization after the first 60 days in a general hospital or after the first 20 days in a skilled nursing facility (Medicare pays 100 percent of the Medicare-approved amount for the first 60 days in a general hospital and the first 20 days of skilled nursing care). The Medicare Supplemental plan also pays the Medicare coinsurance for days 21-100 for skilled nursing care. The Medicare Supplemental plan has an annual maximum benefit of \$6,000 for skilled nursing care.

Medicare Assignment

If the provider accepts Medicare assignment (assigned claims), the provider accepts Medicare’s payment plus the Medicare Supplemental plan’s payment as payment in full. If the provider does not accept Medicare assignment (non-assigned claim), the provider may charge more than what Medicare and the Medicare Supplemental Plan pay combined. The subscriber would pay the difference. See “How Medicare Assignment Works” on Page 13.

Example:

Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

\$7,500	Hospital bill
<u>- 840</u>	Medicare Part A deductible for 2003
\$6,660	Medicare payment

\$ 840 You pay (unless you have another health insurance plan)

If services are provided in South Carolina, the claim will be sent automatically to the SHP. If services are provided outside South Carolina, you will need to send the Explanation of Medicare Benefits (EOMB) to BlueCross BlueShield of South Carolina. If the claim is for mental health or substance abuse services, whether provided inside or outside South Carolina, you will need to send the EOMB to APS Healthcare, Inc. Provider addresses are located on Pages 58-59.

The Medicare Supplemental plan will pay all Medicare deductibles and coinsurance:

\$ 840	Medicare Supplemental plan pays Medicare Part A deductible
<u>+6,660</u>	Amount paid by Medicare
\$7,500	Bill paid in full

Additional information about the Medicare Supplemental Plan is provided in the section “The Medicare Supplemental Plan in Retirement” and in your *Insurance Benefits Guide*.

If You DO Choose the Medicare Supplemental Plan

If you become entitled to Medicare and change to the Medicare Supplemental plan during the year, you must meet a new \$200 deductible for private duty nursing services. You do not have to meet another \$200 deductible for private duty nursing services if you retain the Standard plan.

If You DO NOT Choose the Medicare Supplemental Plan

If you do not select the Medicare Supplemental plan within 31 days of becoming entitled to Medicare, you will not have another opportunity to enroll in that plan until the next open enrollment period.

How the HMO and POS Plans Work Together With Medicare

Companion HealthCare

Companion HealthCare’s (Companion) health maintenance organization (Companion HMO), with or without the Point of Service (Companion-CHOICES) option pays only Medicare-approved charges. Both supplement Medicare by paying the Medicare Part A (hospital) and Part B (medical) deductibles in full. The plans also pay the 20 percent coinsurance left after Medicare pays 80 percent for Part B-approved services.

These two plans pay the coinsurance days for hospitalization after the first 60 days in a general hospital or after the first 20 days in a skilled nursing facility (Medicare pays 100 percent of the Medicare-approved amount for the first 60 days in a general hospital and the first 20 days of skilled nursing care). Companion also pays the Medicare coinsurance for days 21-100 for skilled nursing care.

If the provider accepts Medicare assignment (assigned claims), the provider accepts Medicare's payment plus Companion's payment as payment in full. If the provider does not accept Medicare assignment (non-assigned claim), the provider may charge more than what Medicare and Companion pay combined. The subscriber would pay the difference.

Example:

Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

\$7,500	Hospital bill
<u>- 840</u>	Medicare Part A deductible for 2003
\$6,660	Medicare payment
\$ 840	You pay (unless you have another health insurance plan)

Companion pays all Medicare deductibles and coinsurance:

\$ 840	Companion pays Medicare Part A deductible
<u>+6,660</u>	Amount paid by Medicare
\$7,500	Bill paid in full

Additional information about the Companion plans is provided in the section "HMO and POS Plans in Retirement" and in your *Insurance Benefits Guide*.

CIGNA HealthCare Network

CIGNA HealthCare Network's (CIGNA) health maintenance organization (HMO), with or without the Point of Service (POS) option, pays the lesser of the subscriber's unreimbursed allowable expense under Medicare or CIGNA's normal liability. If the balance due on the claim is less than the normal liability, then CIGNA will pay the balance due.

CIGNA's benefit credit saving provisions apply. A *benefit credit* is the portion of the payment that CIGNA does not have to pay out as part of its normal liability as a result of a coordination of benefits with Medicare. It may be applied as credit toward future claims within the calendar year. *Benefit credit saving* is the difference between CIGNA's normal liability and CIGNA's actual payment. Benefit credit saving applies only to the family member who incurs the charge, and it expires at the end of the calendar year in which it is gained. Contact CIGNA HealthCare Network for additional information.

Example:

Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

\$7,500	Hospital bill
<u>- 840</u>	Medicare Part A deductible
\$6,660	Medicare payment
\$ 840	Balance due

If you are enrolled in CIGNA's HMO or POS plan your claim will be paid like this:

\$7,500	Hospital bill
- 250	CIGNA's inpatient per occurrence copayment
\$7,250	
x 90%	CIGNA's coinsurance
\$6,525	CIGNA's liability in absence of Medicare
- 840	Amount paid by CIGNA in coordination with Medicare
\$5,685	Benefit credit savings with CIGNA

Tips on Choosing a Plan

Examine Your Health Care Needs

Consider your current health care needs when making your coverage decision. Consider the different types of reimbursement offered by the State Health Plan, the HMO and POS plans and how they coordinate with Medicare. Also consider what benefits are offered by these plans for services not generally covered by Medicare, such as prescription drugs or private duty nursing. A chart comparing some of the benefits among these plans is on Pages 36-39.

Think About Your Travel Plans

Medicare does not cover services outside the United States. The Medicare Supplemental plan will not allow benefits for services not covered by Medicare (other than prescription drugs and private duty nursing services). The Standard plan offers worldwide coverage. HMOs and POS plans may have benefit limitations outside of their service areas; check with the providers for more information and what procedures to follow if you need care outside of their service areas.

The State Health Plan in Retirement

This section explains briefly the key distinctions of the State Health Plan (SHP) in retirement. For a more complete overview of the SHP and benefits offered, refer to your *Insurance Benefits Guide*, which is available from your employer or from the Employee Insurance Program (EIP).

General Information Regarding the Standard and Economy Plans

If You Are Not Entitled to Medicare

The state offers you and your eligible dependents a choice between two SHP options—The *Standard plan* or the *Economy plan*. Both the Standard and Economy plans provide the same maximum protection from catastrophic accidents and illnesses; they pay for covered services when medically necessary and ordered by a physician to identify or treat an illness or injury. They also offer certain early detection and preventive benefits.

The plans differ in their deductibles, coinsurance and premiums. Both plans carry worldwide coverage and require Medi-Call approval for inpatient hospital admissions; all maternity benefits (must call in the first trimester); outpatient surgical services in a hospital or clinic; the purchase or rental of durable medical equipment; and skilled nursing care, hospice care and home health care. You must also call APS Healthcare, Inc., administrator for the SHP's Mental Health and Substance Abuse benefits, for preauthorization before you receive mental health or substance abuse care. The in-state hospital, physician, ambulatory surgical center and pharmacy networks, and transplant contracting arrangements, all with predetermined prices for services, apply to both plans. This reduces your out-of-pocket expenses.

If You Are Entitled to Medicare

Once you become entitled to Medicare, the SHP offers a *Medicare Supplemental plan*, which is outlined in the next section. The Economy plan is no longer available to you; however, you may elect to continue coverage under the Medicare Supplemental plan or under the Standard plan which uses a carve-out method of claims payment in conjunction with Medicare (see “How the State Health Plan's Standard Plan Works Together with Medicare” on Page 14).

Deductibles and Coinsurance

SHP Economy Plan

The Economy plan benefit period is from January 1 through December 31 and includes a \$350 individual deductible (\$700 family). An additional \$100 per occurrence deductible applies for each emergency room visit unless you are admitted to the hospital. A separate \$50 per occurrence deductible also applies to each outpatient hospital visit (this deductible is waived for emergency room, dialysis, oncology and physical therapy visits). After you meet the \$350 deductible, benefits are provided at 75 percent of the allowed charges. If you and/or your covered dependents are entitled to Medicare, you may not enroll in the Economy plan.

SHP Standard Plan

The Standard plan benefit period is from January 1 through December 31 and includes a \$250 individual deductible (\$500 family). An additional \$100 per occurrence deductible applies for each emergency room visit unless you are admitted to the hospital. A separate \$50 per occurrence deductible also

applies to each outpatient hospital visit (this deductible is waived for emergency room, dialysis, oncology and physical therapy visits). After you meet the deductible, benefits are provided at 80 percent of the allowed charges. If you and/or your covered dependents are entitled to Medicare, the carve-out method of claims payment applies (explained on Page 14).

Medicare and the SHP Hospital Network

If you are entitled to Medicare, Medicare is the primary payer and you may go to any hospital you choose. Medicare limits the number of days it will cover for hospital stays.

The SHP has a participating hospital network for inpatient and outpatient services in South Carolina. In addition, you have access to participating hospitals across the country and around the world through the BlueCard Program, administered by BlueCross BlueShield of South Carolina. These participating hospitals have agreed to accept the allowable charges for the SHP and will not charge you more for covered expenses. Those not participating in the network may charge you more. Remember to always take your SHP identification card when you travel. For more information about the BlueCard Program and how to locate participating hospitals and doctors, refer to your *Insurance Benefits Guide*.

If You Exceed the Number of Inpatient Hospital Days Allowed Under Medicare

If you are enrolled in the Standard plan and your hospital stay exceeds the number of days allowed under Medicare, it may be important to you that you are admitted to a hospital within the SHP network or BlueCard Program so that you will not be charged more than what the Standard plan allows. *Note: Mental health and substance abuse services are covered only at APS Healthcare, Inc., participating facilities.*

You must also call Medi-Call for approval of any additional inpatient hospital days and for services related to home health care, hospice, durable medical equipment and Veterans Administration hospital services.

Medicare and the SHP Physician Network

Similar to the hospital network, the SHP has a physician network as well. If you're entitled to Medicare and enrolled in the Standard plan, you may want to note that while you are not generally covered outside the United States under Medicare, you have worldwide coverage as part of the BlueCard Program under the SHP. Although you may choose any physician to receive medical services, only network physicians have agreed to accept the prenegotiated rates for covered services. Remember to always take your SHP identification card when you travel.

Using Medi-Call as a Retiree

If you are not entitled to Medicare, as a subscriber of the SHP, you should use Medi-Call for medical and surgical services just as you did as an active employee. If you are entitled to Medicare, Medicare has its own utilization review program. You will still need to call Medi-Call when Medicare benefits are exhausted and for inpatient hospital services (including hospital admissions outside of the state or country), extended care services such as skilled nursing facilities, private duty nursing, home health care, durable medical equipment and Veterans Administration hospital services.

Note: Any covered family members who are not entitled to Medicare and have their claims processed under the SHP must call Medi-Call.

Private Duty Nursing If You Have Medicare

Medicare does not cover private duty nursing; however, the SHP Standard plan does. The standard coinsurance rate applies for approved charges. Remember to call Medi-Call for private duty nursing services.

When Traveling Outside of South Carolina

If you are admitted to a hospital outside of the state or country as a result of an emergency, notify Medi-Call and follow the BlueCard guidelines that are outlined in your *Insurance Benefits Guide*.

Mental Health and Substance Abuse: Using APS As a Retiree

When You Enroll

If you are enrolled in the SHP, you or your covered dependents must register with APS on your first outpatient visit by calling 1-800-221-8699. Precertification and continued stay authorizations by APS are also required for inpatient care. To receive benefits, you must use an APS network provider.

If You Are Entitled to Medicare

If you are entitled to Medicare and you exceed the number of inpatient hospital days covered by Medicare, you must call APS for approval of any additional inpatient hospital days.

Note: Any covered family members who are not entitled to Medicare and have their claims processed under the SHP must call to register with APS.

Prescription Drug Program

The SHP covers prescription drugs when purchased from a participating pharmacy. The Prescription Drug Program is administered by Medco Health Solutions, Inc. If you are entitled to Medicare, please know that Medicare does not provide coverage for prescription drugs, except in a few cases, like certain cancer drugs.

Benefits are not payable if you use a pharmacy that does not participate. Also, if you purchase a brand name medication when a generic is available, you are responsible for paying the difference in price. This difference in price does not apply toward the annual \$1,100 individual copayment maximum. Voluntary mail-order prescription drugs are also offered. Contact Medco Health Solutions, Inc., for details (Page 59). Copayments are included in the comparison charts of health plan benefits, beginning on Page 32. Additional information is also available in your *Insurance Benefits Guide*.

Medicare and the Ambulatory Surgical Center Network

The Ambulatory Surgical Center Network includes facilities throughout the state that provide some of the same services as provided in the outpatient departments of hospitals. These centers accept the SHP's allowed charges and will not charge you more. The \$50 per occurrence outpatient deductible would apply, unless Medicare is primary (see "Deductibles and Coinsurance," on Page 19). If you are entitled to Medicare, there is no need to call Medi-Call for precertification, nor do you need to select a center that participates in the network.

Medicare and Transplant Contracting Arrangements

As part of this network under the SHP, you have access to the leading transplant facilities in the nation,

including instate providers of transplant services. If you are entitled to Medicare, there is no need to call Medi-Call for precertification, nor do you need to select a facility that participates in the network.

Mammography Testing Benefit

The SHP allows female subscribers ages 35-74 to have routine mammograms—one baseline mammogram if you are age 35-39, one routine mammogram every other year if you are age 40-49 and one routine mammogram every year if you are age 50-74—at no cost if you use a facility that participates in the program’s network.

If you are entitled to Medicare, Medicare allows yearly routine mammograms for women age 40 and older and pays 80 percent of Medicare-approved charges. Check with the testing facility to see if it accepts Medicare assignment.

Pap Test Benefit

The SHP will pay for yearly Pap tests for covered women ages 18-65. The Pap test benefit applies whether or not the Pap test is routine or diagnostic. The deductible and coinsurance do not apply to this first-dollar benefit. This benefit does not include the doctor’s office visit or other lab tests. If you are entitled to Medicare, Medicare covers a Pap test, pelvic exam and clinical breast exam every other year (yearly, if you are at high risk. Check with Medicare for more information). Medicare pays 100 percent for the test; 80 percent for the exam and collection.

Maternity Management Benefit and Well Child Care Benefit

The SHP offers two programs geared toward early detection and prevention of illness among children. The Maternity Management benefit helps mothers-to-be covered by the SHP receive necessary prenatal care. (This benefit applies to covered retirees and spouses; it does not apply to dependent children). The Well Child Care benefit offers coverage for routine check-ups and immunizations of children through age 12. If you are entitled to Medicare, please know that Medicare does not provide similar coverage. Refer to your *Insurance Benefits Guide* for more information on these benefits and Plan requirements.

Filing Claims As a Retiree

If you are not entitled to Medicare, file your claims just as you did as an active employee. If you are entitled to Medicare, keep in mind that Medicare is the primary carrier. In most cases, your provider will file your Medicare claims for you.

Claims Filed in South Carolina

The Medicare claim should be filed first. Claims for Medicare-approved charges incurred in South Carolina should be transferred automatically from Medicare to the SHP for you. Your mental health and substance abuse provider should file claims for you with APS, including Medicare payment information. If you or your doctor have not received payment or notification from the SHP within 30 days after the Medicare payment is received, one of you must send BlueCross BlueShield of South Carolina (BCBSSC), claims administrator for the SHP, a claim form and a copy of your Explanation of Medicare Benefits with your SHP subscriber identification number written on it.

Claims Filed Outside South Carolina

If you receive services outside of South Carolina, your provider will file its claim to the Medicare car-

rier in that state. When you receive your Explanation of Medicare Benefits, you must send it to BCBSSC for medical or surgical services or APS for mental health or substance abuse services along with a claim form and itemized bill.

If Medicare Denies Your Claim

If Medicare denies your claim, including denied Pap test claims, you are responsible for filing the denied claim to BCBSSC. You may use the same SHP claim form as active employees do. These forms are available from EIP or BCBSSC. You will need to attach your Explanation of Medicare Benefits and an itemized bill to your claim form.

Railroad Retirement Claims

If you receive benefits from the Railroad Retirement Board (RRB), you must first file claims with the RRB. When you get an explanation of benefits from them, mail it, along with an itemized bill and claim form, to BCBSSC for processing.

The Medicare Supplemental Plan

This section explains briefly the State Health Plan's (SHP) Medicare Supplemental plan, which is available to retirees and covered dependents who are entitled to Medicare. Additional information may be found in your *Insurance Benefits Guide*.

General information

The Medicare Supplemental plan is similar to a Medigap policy—it fills the “gap” or pays the portion of approved charges that Medicare does not, such as Medicare's deductibles and coinsurance. The Medicare Supplemental plan adheres to Medicare-approved charges. If your medical provider does not accept Medicare assignment, explained in “How the Medicare Supplemental plan Works With Medicare” on Page 15, and charges you more than what Medicare allows, you pay the difference.

Medicare Deductibles and Coinsurance

Deductibles

Under Medicare, you must pay the Part A inpatient hospital deductible for each benefit period. That deductible is \$840 for 2003. A Medicare benefit period begins the day you go to a hospital or skilled nursing facility and ends when you have not received any hospital or skilled care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. *The Medicare Supplemental plan pays the Part A deductible.*

Medicare Part B has a deductible of \$100 per year. Part B also includes a monthly premium of \$58.70 for 2003 and covers physician services, supplies and outpatient care. As a retiree, you should enroll in Part B as soon as you are entitled to Medicare, as Medicare becomes primary. *The Medicare Supplemental plan pays the Part B deductible.*

Coinsurance

Medicare Part B pays 80 percent of Medicare-approved charges (50 percent for outpatient mental health care). *The Medicare Supplemental plan pays the remaining 20 percent (50 percent for outpatient mental health care).*

Medicare Supplemental Plan Deductibles and Coinsurance

The Medicare Supplemental plan benefit period is from January 1 through December 31 and includes a \$200 deductible each calendar year that applies to private duty nursing services only.

What the Medicare Supplemental Plan Covers

Hospital Admissions

The Medicare Supplemental plan pays the following benefits for Medicare-covered services after Medicare Part A benefits have been paid during a benefit period:

- The Medicare Part A hospital deductible;
- The coinsurance, after Medicare pays, for days 61-150 of hospitalization, up to the Medicare-approved charge (Medicare pays 100 percent for the first 60 days);

- 100 percent of Medicare-approved charges for hospitalization beyond 150 days, if medically necessary (Medicare does not pay beyond 150 days)*;
- The coinsurance for durable medical equipment up to the Medicare-approved charge*.

**Must call Medi-Call for approval.*

Skilled Nursing Facilities

The Medicare Supplemental plan will pay the following benefits after Medicare has paid benefits during a benefit period:

- The coinsurance, after Medicare pays, up to the Medicare-approved charge for days 21-100 (Medicare pays 100 percent for the first 20 days);
- 100 percent of the Medicare-approved charges beyond 100 days in a skilled nursing facility if medically necessary (Medicare does not pay beyond 100 days).* The maximum benefit per year is \$6,000.

**Must call Medi-Call for approval.*

Physician Charges

The Medicare Supplemental plan will pay the following benefits related to physician services approved by Medicare:

- The Medicare Part B deductible;
- The coinsurance of the Medicare-approved charge for physician's services for surgery, necessary home and office visits, in hospital visits and other covered physician's services;
- The coinsurance for Medicare-approved charges for physician's services rendered in the outpatient department of a hospital for treatment of accidental injury, medical emergencies, minor surgery and diagnostic services.

Home Health Care

The Medicare Supplemental plan will pay the following benefits for medically necessary home health care services:

- The Medicare Part B deductible;
- The coinsurance for any covered services or costs Medicare does not cover (Medicare pays 100 percent for Medicare-approved charges), up to 100 visits or \$5,000 per benefit year, whichever occurs first.

The plan does not cover services provided by a person who ordinarily resides in the home, is a member of the family or a member of the family of the spouse of the covered person.

Private Duty Nursing Services (not covered by Medicare)

Private services provided by a registered nurse (RN) or a licensed practical nurse (LPN) that have been certified in writing by a physician as medically necessary. There is a \$200 annual deductible that applies, regardless of the time of year you enroll in the plan.

Once the deductible is met, the Medicare Supplemental plan will pay 80 percent of covered charges for private duty nursing in a hospital or in the home. Coverage is limited to no more than three nurses per day, and the maximum annual benefit per year is \$5,000. The lifetime maximum benefit under the Medicare Supplemental plan is \$25,000.

Prescription Drugs

Although Medicare does not provide coverage for prescription drugs, except in a few cases, like certain cancer drugs, the Supplemental plan covers prescription drugs when purchased from a participating pharmacy under the SHP's Prescription Drug Program, administered by Medco Health Solutions, Inc. Voluntary mail-order prescription drugs are also offered. Contact Medco Health Solutions, Inc., for details (Page 59). Copayments are included in the comparison charts of health plan benefits on Pages 32-39. Additional information is in your *Insurance Benefits Guide*.

Medicare and the SHP Hospital Network

If you are entitled to Medicare, Medicare is the primary payer, and you may go to any hospital you choose. However, Medicare limits the number of days it will cover you for hospital stays—Medicare pays nothing for hospital stays beyond 150 days.

If You Exceed the Number of Inpatient Hospital Days Allowed Under Medicare

If you are enrolled in the Supplemental plan and you exhaust all Medicare-allowed inpatient hospital days, you must call Medi-Call for approval of any additional inpatient hospital days. If your extended stay is approved, the Supplemental plan will pay for the Medicare-approved expenses. So, if you are enrolled in the Supplemental plan and you expect your hospital stay may exceed the number of days allowed under Medicare, you should choose a hospital within the SHP network so that any additional days beyond what Medicare allows will be covered by the Supplemental Plan. *Note: Mental health and substance abuse services are covered at APS Healthcare, Inc., participating facilities.*

You must also call Medi-Call for services related to home health care, hospice, durable medical equipment and Veterans Administration hospital services.

When Traveling Outside the United States

Although the SHP hospital network also includes participating hospitals across the country and around the world through the BlueCard Program, administered by BlueCross BlueShield of South Carolina, Medicare does not cover services outside the United States. Since the Medicare Supplemental plan does not allow benefits for services not covered by Medicare (other than prescription drugs and private duty nursing), the BlueCard Program does not apply to Medicare Supplemental plan subscribers.

Medicare and Using Medi-Call

Medicare has its own utilization review program. You will need to call Medi-Call when Medicare benefits are exhausted for inpatient hospital services, extended care services such as skilled nursing facilities, private duty nursing, home health care, durable medical equipment and Veterans Administration hospital services.

Note: Any covered family members who are not entitled to Medicare and have their claims processed under the SHP must call Medi-Call.

Mental Health and Substance Abuse: When to Call APS

If your claims are processed under the Medicare Supplemental plan, you do not need to call APS Healthcare, Inc., (APS) administrator of the SHP Mental Health and Substance Abuse benefit, because Medicare guidelines will apply. However, if you exhaust Medicare's allowed inpatient hospital days, you must call APS for approval of any additional inpatient hospital days. Precertification and continued stay authorizations from APS are required for inpatient care; however, you are not required to use an APS network provider.

Note: Any covered family members who are not entitled to Medicare and have their claims processed under the SHP must call to register with APS.

Medicare and the Ambulatory Surgical Center Network

The Ambulatory Surgical Center Network includes facilities throughout the state that provide some of the same services as provided in the outpatient departments of hospitals. These centers accept the SHP's allowed charges and will not charge you more. If you are entitled to Medicare, there is no need to call Medi-Call for precertification, nor do you need to select a center that participates in the SHP network.

Medicare and Transplant Contracting Arrangements

As part of this network under the SHP, you have access to the leading transplant facilities in the nation, including instate providers of transplant services. If you are entitled to Medicare, there is no need to call Medi-Call for precertification, nor do you need to select a facility that participates in the SHP network.

Mammography Testing Benefit

If you are entitled to Medicare, Medicare allows yearly routine mammograms for women ages 40 and older and pays 80 percent of the Medicare-approved amount. The Supplemental plan pays the 20 percent coinsurance.

Pap Test Benefit

If you are entitled to Medicare, Medicare covers a Pap test, pelvic exam and clinical breast exam every other year (yearly, if you are at high risk. Check with Medicare for more information). Medicare pays 100 percent for the Pap lab test; 80 percent of the Medicare-approved amount for the Pap test collection and the pelvic and breast exam. The Supplemental plan pays the 20 percent coinsurance.

Note that the Supplemental plan will pay for Pap tests for covered women, ages 18-65, *every year*, so you may take advantage of this benefit in the years that Medicare does *not* pay. The Pap test benefit applies whether or not the Pap test is routine or diagnostic. The deductible and coinsurance do not apply to this first-dollar benefit. This benefit does not include the doctor's office visit or other lab tests.

Maternity Management Benefit and Well Child Care Benefit

The Supplemental plan offers benefits geared toward early detection and prevention of illness among children. The Maternity Management benefit helps mothers-to-be covered by the SHP receive necessary prenatal care. (This benefit applies to covered retirees and spouses; it does not apply to dependent children). The Well Child Care benefit offers coverage for routine check-ups and immunizations of children through age 12. If you are entitled to Medicare, you may want to know that Medicare does not provide similar coverage. Refer to your *Insurance Benefits Guide* for more information on these benefits.

Filing Claims As a Retiree

If you are not entitled to Medicare, file your claims just as you did as an active employee. If you are entitled to Medicare, keep in mind that Medicare is the primary carrier. In most cases, your provider will file your Medicare claims for you.

Claims Filed Inside South Carolina

The Medicare claim should be filed first. Claims for Medicare-approved charges incurred in South Carolina should be transferred automatically from Medicare to the SHP for you. Your mental health and substance abuse provider should file claims to APS with Medicare payment information. If you or your doctor has not received payment or notification from the Plan within 30 days after the Medicare payment is received, one of you must send BlueCross BlueShield of South Carolina (BCBSSC), claims administrator for the SHP, a claim form and a copy of your Explanation of Medicare Benefits with your subscriber identification number written on it.

Claims for covered family members not entitled to Medicare but insured through the Medicare Supplemental plan are paid through the Standard plan. The carve-out method does not apply to family members who are not entitled to Medicare.

Claims Filed Outside South Carolina

If you receive services outside of South Carolina, your provider will file its claim to the Medicare carrier in that state. When you receive your Explanation of Medicare Benefits, you must send it to BCBSSC for medical or surgical services or APS for mental health or substance abuse services along with a claim form and itemized bill.

If Medicare Denies Your Claim

If Medicare denies your claim, including denied Pap test claims, you are responsible for filing the denied claim to BCBSSC. You may use the same SHP claim form as active employees do. These forms are available from EIP or BCBSSC. You will need to attach your Explanation of Medicare Benefits and an itemized bill to your claim form.

Railroad Retirement Claims

If you receive benefits from the Railroad Retirement Board (RRB), you must first file claims with the RRB. When you get an explanation of benefits from them, mail it, along with an itemized bill and claim form, to BCBSSC for processing.

HMO and POS Plans in Retirement

This section explains briefly some key distinctions of the traditional health maintenance organizations (HMOs) and HMOs with Point of Service (POS) options and how they work together with Medicare. For a more complete overview of the plans, refer to your *Insurance Benefits Guide*, which is available from your employer or from the Employee Insurance Program (EIP).

Availability

The following traditional HMOs and POS plans are available to retirees, COBRA subscribers and survivors:

- Companion HMO
- CIGNA HealthCare Network HMO
- Companion-CHOICES (POS)
- CIGNA HealthCare Network POS
- MUSC Options (Not available to those who are entitled to Medicare)

You must live in an HMO or POS plan's service area to enroll. Not all HMOs or POS plans are available in all service areas. A list of service areas may be found on Page 6.

If You Are Entitled to Medicare

MUSC Options is not available if you or your covered dependents are entitled to Medicare. However, the other HMOs and POS plans are available if you live in their service area.

Provider Networks

Traditional HMOs provide a list of participating network doctors from which you choose a primary care physician. This doctor coordinates your care, which means you must contact him to be referred to specialists who also participate within the HMO's network. Network providers file the claims for you. If you belong to an HMO, the plan covers only medical services received within its network of providers. If you receive care outside of the network, benefits are not paid. Typically, the only services you receive from out-of-network providers that most HMOs cover are those for emergency medical conditions.

A POS plan is an HMO plan that allows you to selectively go to a provider outside of its network. When you do so, you are likely to have much higher out-of-pocket expenses in the form of deductibles and copayments.

When Traveling Outside the Network or the United States

When traveling outside the CIGNA HealthCare, Companion or MUSC Options networks, you will be covered for emergency medical care. If your insurance identification cards are not recognized by the treating hospital, you may be required to pay for the services, then later file a claim for reimbursement.

Prescription Drug Programs

All HMOs and POS plans offered for 2003 include a prescription drug program. If you are entitled to Medicare, you may want to know that Medicare does not provide coverage for prescription drugs,

except in a few cases, like certain cancer drugs. Copayments are included in the comparison charts of health plan benefits, beginning on Page 32. Additional information is also available in your *Insurance Benefits Guide*.

Filing Claims As a Retiree

If you are not entitled to Medicare, file your claims just as you did as an active employee. If you are entitled to Medicare, keep in mind that Medicare is the primary carrier. In most cases, your provider will file your Medicare claims for you. The Medicare claim should be filed first.

For additional information on the HMOs and POS plans coordinate their benefits with Medicare, refer to “How the HMO and POS Plans Work Together with Medicare” on Page 16.

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Comparison of Health Plan Benefits for Retire

TYPE	PREFERRED PROVIDER ORGANIZATION		TRADITIONAL HMO	
	Subscribers can choose any provider in- or out-of-network. Benefits out-of-network are not reduced, but subscribers risk being balanced billed.		All care must be directed by a primary care physician (PCP) and approved by the HMO.	
PLAN	SHP ECONOMY PLAN	SHP STANDARD PLAN	COMPANION HMO	CIGNA* HMO
SERVICE AREAS	Coverage worldwide	Coverage worldwide	Service areas: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	Service areas: 2, 3, 7, 8, 9, 10, 11, 12
CANCELLATION POLICY	Cancelled upon request or for non-payment of premiums	Cancelled upon request or for non-payment of premiums	Cancelled upon request or for non-payment of premiums	Cancelled upon request or for non-payment of premiums
ANNUAL DEDUCTIBLE			None	None
Single	\$350	\$250		
Family	\$700	\$500		
PER OCCURRENCE DEDUCTIBLE	Outpatient hospital: \$50 deductible Emergency care: \$100 deductible (call Medi-Call to avoid \$200 penalty)	Outpatient hospital: \$50 deductible Emergency care: \$100 deductible (call Medi-Call to avoid \$200 penalty)	Inpatient: \$200 copay Outpatient: \$75 copay Emergency care: \$75 copay	Inpatient: \$250 copay Outpatient facility: \$125 copay Emergency care: \$75 copay
COINSURANCE	Plan pays 75% You pay 25%	Plan pays 80% You pay 20%	Plan pays 90% You pay 10%	Plan pays 90% You pay 10%
COINSURANCE MAXIMUM	\$1,500 \$3,000 (excludes deductible)	\$1,500 \$3,000 (excludes deductible)	\$1,500 \$3,000 (excludes copays)	\$2,000 \$4,000 (excludes certain copays)
PHYSICIAN VISITS	Coinsurance: Plan pays 75% You pay 25% Well child care visits and immunizations paid at 100% (in network) through age 12	Coinsurance: Plan pays 80% You pay 20% Well child care visits and immunizations paid at 100% (in network) through age 12	\$15 PCP copayment \$15 OB/GYN well woman exam \$25 specialist copay \$35 urgent care copay	\$15 PCP copayment \$25 OB/GYN copay \$25 specialist copay
PRESCRIPTION DRUGS	Participating pharmacies only: \$7 generic \$22 name brand (up to 31-day supply) Mail-order available (up to 90-day supply): \$16 generic, \$50 brand name “Pay-the-difference” policy applies	Participating pharmacies only: \$7 generic \$22 name brand (up to 31-day supply) Mail-order available (up to 90-day supply): \$16 generic, \$50 brand name “Pay-the-difference” policy applies	Participating pharmacies only: \$7 generic \$25 preferred brand \$40 nonpreferred brand (up to 31-day supply) Mail-order (up to 90-day supply): \$21 generic; \$75 preferred brand name; \$120 non-preferred brand name	Participating pharmacies only: \$10 generic \$20 preferred brand \$40 nonpreferred brand (up to 30-day supply) Mail-order (up to 90-day supply): \$20 generic; \$40 preferred brand name; \$80 non-preferred brand name
MENTAL HEALTH/ SUBSTANCE ABUSE	Participating providers only. Call 1-800-221-8699. Subject to above deductibles and coinsurance.	Participating providers only. Call 1-800-221-8699. Subject to above deductibles and coinsurance.	Participating providers only. Call 1-800-868-1032. Inpatient: \$200 copay, then 90% covered; Outpatient: \$25 specialist copay	Participating providers only. Inpatient: \$250 copay, then 90% covered Outpatient: \$25 specialist copay
LIFETIME MAXIMUM	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000

*CIGNA HealthCare Network

es and Dependents NOT Entitled to Medicare

HMO WITH POINT OF SERVICE (POS) OPTION					
To receive the higher level of benefits, care must be directed by a primary care physician (PCP) and approved by the HMO. Medically necessary benefits are available out-of-network at a lower benefit level.					
COMPANION-CHOICES		CIGNA* POS		MUSC Options	
Service areas: 1, 2		Service areas: 1, 5		Service area: 11	
Cancelled upon request or for non-payment of premiums		Cancelled upon request or for non-payment of premiums		Cancelled upon request or for non-payment of premiums	
<u>In-network</u>	<u>Out-of-network</u>	<u>In-network</u>	<u>Out-of-network</u>	<u>In-network</u>	<u>Out-of-network</u>
None	\$500 per individual	None	\$500 \$1,000	None	\$300 \$900
Inpatient: \$200 copay Outpatient Surgery: \$75 copay Emergency care: \$75 copay	Inpatient: \$250 copay Outpatient Surgery: \$125 copay Emergency care: \$75 copay	Inpatient: \$250 copay Outpatient facility: \$125 Emergency care: \$75 copay	Inpatient: \$250 copay Emergency care: \$75 copay	Inpatient: \$250 copay Outpatient Facility: \$75 copay Emergency care: \$75 copay	Annual deductibles only
Plan pays 90% after copays	Plan pays 70% after deductible and copays	Plan pays 90% after copays	Plan pays 60% after deductible and copays	Plan pays 100% after copays	Plan pays 60% of allowance You pay 40%
\$1,500 \$3,000 (excludes copays)	\$3,000 \$6,000 (excludes copays and deductible)	\$2,000 \$4,000 (excludes certain copays)	\$4,000 \$8,000 (excludes certain copays and deductible)	N/A	\$3,000 \$9,000 (excludes deductibles)
\$15 PCP copay \$15 OB/GYN well woman exam \$25 specialist copay \$35 urgent care copay	Coinsurance: Plan pays 70% of allowance after annual deductible You pay 30%	\$15 PCP copay \$25 OB/GYN copay \$25 specialist copay	Coinsurance: Plan pays 60% of allowance You pay 40%	\$15 PCP copay \$15 OB/GYN well woman exam \$25 specialist copay with referral \$45 specialist copay without referral	Coinsurance: Plan pays 60% of allowance after annual deductible You pay 40% No preventive care benefits out-of-network
Participating pharmacies only: \$7 generic \$25 preferred brand \$40 nonpreferred brand (up to 31-day supply) Mail-order (up to 90-day supply): \$21 generic; \$75 preferred brand name; \$120 nonpreferred brand name		Participating pharmacies only: \$10 generic; \$20 preferred brand; \$40 nonpreferred brand (up to 30-day supply) Mail-order (up to 90-day supply): \$20 generic; \$40 preferred brand name; \$80 nonpreferred brand name	HMO pays 60% of allowance after annual deductible You pay 40% (up to 30-day supply) Mail-order is excluded out-of-network	Participating pharmacies only: \$10 generic \$25 preferred brand \$40 nonpreferred brand (up to 31 day supply) Mail-order available (90 day supply): \$15 generic, \$50 preferred brand, \$80 nonpreferred brand	
Participating providers only. Call 1-800-868-1032. Inpatient: \$200 copay, then 90% covered Outpatient: \$25 specialist copay		Participating providers only. Inpatient: \$250 copay, then 90% covered Outpatient: \$25 specialist copay	Inpatient: \$250 copay, then 60% covered Outpatient: 60% covered	Inpatient: \$250 copay Outpatient: \$25 copay with referral, \$45 copay without referral	Coinsurance: Plan pays 60% of allowance after annual deductible You pay 40%
\$1,000,000		\$1,000,000		\$1,000,000	

Comparison of Health Plan Benefits for Retirees

	PREFERRED PROVIDER ORGANIZATION		TRADITIONAL HMO	
PLAN	SHP ECONOMY PLAN	SHP STANDARD PLAN	COMPANION HMO	CIGNA* HMO
INPATIENT HOSPITAL DAYS¹	Plan pays 75% You pay 25% with coinsurance maximum (Medi-Call required)	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	Plan pays 90% You pay 10% with \$200 copay and coinsurance maximum	Plan pays 90% You pay 10% with \$250 copay and coinsurance maximum
SKILLED NURSING CARE	Plan pays 75% You pay 25% up to \$6,000 or 60 days, whichever is less (Medi-Call required)	Plan pays 80% You pay 20% up to \$6,000 or 60 days, whichever is less (Medi-Call required)	Plan pays 90% You pay 10% up to 120 days	Plan pays 90% You pay 10% up to 180 days
PRIVATE DUTY NURSING	Plan pays 75% You pay 25% with coinsurance maximum (Medi-Call required)	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	Plan pays 90% You pay 10% up to 60 days	Plan pays 100%
HOME HEALTH CARE	\$5,000 or 100 visits (whichever is less) if Medi-Call approved	\$5,000 or 100 visits (whichever is less) if Medi-Call approved	Plan pays 90% You pay 10%	Plan pays 100% up to 60 visits
HOSPICE CARE	\$6,000 lifetime maximum, including \$200 bereavement counseling	\$6,000 lifetime maximum, including \$200 bereavement counseling	Plan pays 90% You pay 10%	Plan pays 100%
DURABLE MEDICAL EQUIPMENT	Plan pays 75% You pay 25% with coinsurance maximum (Medi-Call required)	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	\$5,000 maximum Plan pays 90% You pay 10%	\$3,500 maximum Plan pays 100%
ROUTINE MAMMOGRAPHY SCREENING	Ages 35 through 74 in participating facilities only; guidelines apply	Ages 35 through 74 in participating facilities only; guidelines apply	Plan pays 100%; guidelines apply	Plan pays 100%
PAP TEST	Ages 18 through 65 routine or diagnostic	Ages 18 through 65 routine or diagnostic	Routine: any age; 2 per year; \$15 copay. Diagnostic: copay/coinsurance	Plan pays 100% You pay \$25 copay
AMBULANCE	Plan pays 75% You pay 25% with coinsurance maximum for emergency transport	Plan pays 80% You pay 20% with coinsurance maximum for emergency transport	Plan pays 90% You pay 10%	Plan pays 90% You pay 10%
EYEGLASSES/ HEARING AID	None, except for prosthetic lenses from cataract surgery. Discount under Vision Care Program. (Refer to your <i>Insurance Benefits Guide</i> for details.)	None, except for prosthetic lenses from cataract surgery. Discount under Vision Care Program. (Refer to your <i>Insurance Benefits Guide</i> for details.)	One exam for glasses or contacts per year (\$45 copay for contacts exam). One pair glasses every other year (from designated selection).	Discount available through CIGNA Healthy Rewards program

*CIGNA HealthCare Network

¹Semi-private room and board, physician/surgeon charges, operating/delivery room and recovery room, general nursing and miscellaneous hospital services and supplies.

and Dependents NOT Entitled to Medicare (cont.)

HMO WITH POINT OF SERVICE (POS) OPTION

COMPANION-CHOICES POS		CIGNA* POS		MUSC Options	
<u>In-network</u>	<u>Out-of-network</u>	<u>In-network</u>	<u>Out-of-network</u>	<u>In-network</u>	<u>Out-of-network</u>
Plan pays 90% You pay 10% with \$200 copay and coinsurance maximum	Plan pays 70% You pay 30% with \$250 copay and coinsurance maximum	Plan pays 90% You pay 10% with \$250 copay and coinsurance maximum	Plan pays 60% You pay 40% with \$250 copay and coinsurance maximum	Plan pays 100% You pay \$250 copay	Plan pays 60% You pay 40% with coinsurance maximum
Plan pays 90% You pay 10% up to 120 days	Covered in-network only	Plan pays 90% You pay 10% up to 180 days	Plan pays 60% You pay 40% up to 180 days	Plan pays 100% up to \$6,000 or 60 days, whichever is less	Plan pays 60% You pay 40% subject to deductible
Plan pays 90% You pay 10% up to 60 days	Plan pays 70% You pay 30%, subject to deductible	Plan pays 100%	Plan pays 60% You pay 40%	Plan pays 100%	Covered in-network only
Plan pays 90% You pay 10%	Plan pays 70% You pay 30%, subject to deductible	Plan pays 100% up to 60 visits	Plan pays 60% You pay 40% up to 60 visits	Plan pays 100% up to \$5,000 or 100 visits, whichever is less	Plan pays 60% You pay 40% subject to deductible
Plan pays 90% You pay 10%	Plan pays 70% You pay 30%, subject to deductible	Plan pays 100%	Plan pays 60% You pay 40%	Plan pays 100% 6,000 lifetime maximum	Plan pays 60% You pay 40% subject to deductible
\$5,000 maximum Plan pays 90% You pay 10%	Covered in-network only	\$3,500 maximum Plan pays 100%	Covered in-network only	Plan pays 100%	Covered in-network only
Plan pays 100%; guidelines apply	Plan pays 70% You pay 30%, subject to deductible	Plan pays 100%	Covered in-network only	Plan pays 100%	Covered in-network only
Routine: any age; 2 per year; \$15 copay. Diagnostic: copay/coinsurance	Covered in-network only	Plan pays 100% You pay \$25 copay	Covered in-network only	Routine: any age; 2 per year; \$15 copay. Diagnostic: copay/coinsurance	Covered in-network only
Plan pays 90% You pay 10%	Plan pays 70% You pay 30%, subject to deductible	Plan pays 90% You pay 10%	Plan pays 60% You pay 40%	Plan pays 100%	Plan pays 60% You pay 40% subject to deductible
One exam for glasses or contacts per year (\$45 copay for contacts exam). One pair glasses every other year (from designated selection).	Covered in-network only	Discount available through CIGNA Healthy Rewards program	Discount available through CIGNA Healthy Rewards program	One exam for glasses or contacts per year (\$45 copay for contacts exam). One pair glasses every other year (from designated selection).	Covered in-network only

Comparison of Health Plan Benefits for

TYPE			PPO
			May use any provider in- or out-of-network. Benefits out-of-network are not reduced, but subscribers risk being balanced billed.
PLAN	MEDICARE	MEDICARE SUPPLEMENTAL	SHP STANDARD PLAN
SERVICE AREAS	United States (Contact Medicare for information about services outside the United States)	Same as Medicare	Coverage worldwide
CANCELLATION POLICY	None	Cancelled upon request or for non-payment of premiums	Cancelled upon request or for non-payment of premiums
ANNUAL DEDUCTIBLE	Part A: \$840 (per benefit period) Part B: \$100	Pays Medicare Part A and Part B deductibles	\$250 (single) \$500 (family) Carve-out method applies
PER OCCURRENCE DEDUCTIBLE	Inpatient hospital: Part A deductible (\$840 per benefit period)	Pays Medicare Part A deductible (Call Medi-Call for hospital stays exceeding 150 days, skilled nursing, private duty nursing, home health care durable medical equipment and VA hospital services)	Outpatient hospital: \$50 deductible Emergency care: \$100 deductible (Call Medi-Call for hospital stays exceeding 150 days, skilled nursing, private duty nursing, home health care durable medical equipment and VA hospital services)
COINSURANCE	Part A: 100% Part B: 80% (you pay 20%)	Pays Part B coinsurance of 20%	Carve-out method applies Plan allows 80%
COINSURANCE MAXIMUM	None	None	\$1,500 (single) \$3,000 (family) (excludes deductible)
PHYSICIAN VISITS	Plan pays 80% You pay 20% Routine annual physicals and OB/GYN exams not covered	Plan pays Part B coinsurance of 20%	Carve-out method applies Plan allows 80% Well child care visits and immunizations paid at 100% (in network) through age 12
PRESCRIPTION DRUGS	No coverage, except for certain cancer drugs	Participating pharmacies only: \$7 generic \$22 name brand (up to 31-day supply) Mail-order available (up to 90-day supply): \$16 generic, \$50 brand name \$1,100 copayment maximum “Pay-the-difference” policy applies	Participating pharmacies only: \$7 generic \$22 name brand (up to 31-day supply) Mail-order available (up to 90-day supply): \$16 generic, \$50 brand name \$1,100 copayment maximum “Pay-the-difference” policy applies
MENTAL HEALTH/ SUBSTANCE ABUSE	Inpatient: Plan pays 100% for days 1-60 (Part A deductible applies); You pay \$210/day for days 61-90; You pay \$420/day for days 91-150 (subject to 60 lifetime reserve days); You pay all costs beyond 150 days. Outpatient: Plan pays 50% (Part B deductible applies)	Inpatient: Plan pays Medicare deductible; \$210 coinsurance for days 61-90; \$420 coinsurance for days 91-150; 100% beyond 150 days (APS approval required). Outpatient: Plan pays Medicare deductible, 50% coinsurance	Plan allows 80% (APS participating providers only if hospital stay exceeds 150 days) (carve-out method applies)
LIFETIME MAXIMUM	None	\$1,000,000	\$1,000,000

*CIGNA HealthCare Network

Retirees and Dependents Entitled to Medicare

TRADITIONAL HMO		HMO WITH POINT OF SERVICE (POS) OPTION			
All care must be directed by a primary care physician (PCP) and approved by the HMO.		To receive the higher level of benefits, care must be directed by a primary care physician (PCP) and approved by the HMO. Medically necessary benefits are available out-of-network at a lower benefit level.			
COMPANION HMO	CIGNA* HMO	COMPANION-CHOICES POS		CIGNA* POS	
Service areas: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	Service areas: 2, 3, 7, 8, 9, 10, 11, 12	Service areas: 1, 2		Service areas: 1, 5	
Cancelled upon request or for non-payment of premiums	Cancelled upon request or for non-payment of premiums	Cancelled upon request or for non-payment of premiums		Cancelled upon request or for non-payment of premiums	
Pays Medicare Part A and Part B deductibles	No deductible; Pays lesser of unreimbursed Medicare-allowed expense or plan's normal allowance	<u>In-network</u> Pays Medicare Part A and Part B deductibles	<u>Out-of-network</u> Pays Medicare Part A and Part B deductibles	<u>In-network</u> No deductible; Pays lesser of unreimbursed Medicare-allowed expense or plan's normal allowance	<u>Out-of-network</u> \$500 (single) \$1,000 (family) Pays lesser of unreimbursed Medicare-allowed expense or plan's normal allowance
Pays Medicare Part A deductible	Inpatient: \$250 copay Outpatient facility: \$125 copay Emergency care: \$75 copay	Pays Medicare Part A deductible	Pays Medicare Part A deductible	Inpatient: \$250 copay Outpatient facility: \$125 copay Emergency care: \$75 copay	Inpatient: \$250 copay Emergency care: \$75 copay
Pays Part B coinsurance of 20%	Plan pays 90% or unreimbursed Medicare-allowed expense	Pays Part B coinsurance of 20%	Pays Part B coinsurance of 20%	Plan pays 90% or unreimbursed Medicare-allowed expense	Plan pays 60% after deductible and copays or unreimbursed Medicare-allowed expense
None	\$2,000 (single) \$4,000 (family) (excludes certain copays)	None	None	\$2,000 (single) \$4,000 (family) (excludes certain copays)	\$4,000 (single) \$8,000 (family) (excludes certain copays and deductible)
Plan pays Part B coinsurance of 20%	\$15 PCP copayment \$25 OB/GYN copay \$25 specialist copay Plan pays 90% or unreimbursed Medicare-allowed expense	Plan pays Part B coinsurance of 20%	Plan pays Part B coinsurance of 20%	\$15 PCP copay \$25 OB/GYN copay \$25 specialist copay Plan pays 90% or unreimbursed Medicare-allowed expense	Coinsurance: Plan pays 60% after annual deductible or unreimbursed Medicare-allowed expense
Participating pharmacies only: \$7 generic \$25 preferred brand \$40 nonpreferred brand (up to 31-day supply) Mail-order (up to 90-day supply): \$21 generic; \$75 preferred brand; \$120 non-preferred brand	Participating pharmacies only: \$10 generic \$20 preferred brand \$40 nonpreferred brand (up to 30-day supply) Mail-order (up to 90-day supply): \$20 generic; \$40 preferred brand; \$80 non-preferred brand	Participating pharmacies only: \$7 generic \$25 preferred brand \$40 nonpreferred brand (up to 31-day supply) Mail-order (up to 90-day supply): \$21 generic; \$75 preferred brand; \$120 nonpreferred brand		Participating pharmacies only: \$10 generic; \$20 preferred brand; \$40 nonpreferred brand (up to 30-day supply) Mail-order (up to 90-day supply): \$20 generic; \$40 preferred brand; \$80 non-preferred brand	Plan pays 60% of allowance You pay 40% (up to 30-day supply) Mail-order is excluded out-of-network
Inpatient: Plan pays Medicare deductible; \$210 coinsurance for days 61-90; \$420 coinsurance for days 91-150; 100% beyond 150 days. Outpatient: Plan pays Medicare deductible, 50% coinsurance	Participating providers only. Inpatient: \$250 copay; Outpatient: \$25 specialist copay Plan pays 90% or unreimbursed Medicare-allowed expense.	Inpatient: Plan pays Medicare deductible; \$210 coinsurance for days 61-90; \$420 coinsurance for days 91-150; 100% beyond 150 days (Medi-Call approval required). Outpatient: Plan pays Medicare deductible, 50% coinsurance		Inpatient: \$250 copay, Outpatient: \$25 specialist copay Plan pays 90% or unreimbursed Medicare-allowed expense.	Inpatient: \$250 copay, then 60% or unreimbursed Medicare-allowed expense Outpatient: Plan pays 60% or unreimbursed allowable expense after Medicare
\$1,000,000	\$1,000,000	\$1,000,000		\$1,000,000	

Comparison of Health Plan Benefits for Retirees

			PPO
PLAN	MEDICARE	MEDICARE SUPPLEMENTAL	SHP STANDARD PLAN
INPATIENT HOSPITAL DAYS¹	Plan pays 100% for days 1-60 (Part A deductible applies); You pay \$210/day for days 61-90; You pay \$420/day for days 91-150 (subject to 60 lifetime reserve days); You pay all costs beyond 150 days.	Plan pays: Medicare deductible; \$210 coinsurance for days 61-90; \$420 coinsurance for days 91-150; 100% beyond 150 days (Medi-Call approval required)	Plan allows 80% (carve-out method applies) (Call Medi-Call if hospital stay exceeds 150 days)
SKILLED NURSING CARE	Plan pays 100% for days 1-20; You pay \$105 for days 21-100	Plan pays \$105 for days 21-100; Plan pays 100% beyond 100 days (Medi-Call approval required)	Plan allows 80% (carve-out method applies), up to \$6,000 or 60 days, whichever is less. (Call Medi-Call if hospital stay exceeds 100 days)
PRIVATE DUTY NURSING	Not covered	\$200 annual deductible Plan pays 80% if Medi-Call approved You pay 20% \$5,000 annual max./\$25,000 lifetime	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call approval required)
HOME HEALTH CARE	Plan pays 100%	Medi-Call available to assist with referrals	Plan allows 80% (carve-out applies) You pay 20% up to \$5,000 or 100 visits, whichever is less
HOSPICE CARE	Plan pays 100%	Medi-Call available to assist with referrals	Medi-Call available to assist with referrals
DURABLE MEDICAL EQUIPMENT	Plan pays 80% (Medicare approval required) You pay 20%	Plan pays 20% coinsurance (Medi-Call required)	Plan allows 80% (carve-out applies) (Medi-Call approval required)
ROUTINE MAMMOGRAPHY SCREENING	Age 40 and older, one every year Plan pays 80% You pay 20%	Plan pays 20% coinsurance	Ages 35 through 74 in participating facilities only; guidelines apply
PAP TEST	Routine every two years (yearly if high risk) Plan pays 100% for Pap test Plan pays 80% for exam	Plan pays 20% coinsurance. Otherwise, pays routine ages 18 through 65 routine or diagnostic; diagnostic only age 66 and older	Routine yearly ages 18 through 65 routine; diagnostic only age 66 and older; Plan allows 100% for Pap test (carve-out applies when Medicare pays)
AMBULANCE	Plan pays 80% You pay 20%	Plan pays 20% coinsurance	Plan allows 80% (carve-out method applies)
EYEGLASSES/ HEARING AID	None, except for prosthetic lenses from cataract surgery. Discount under Vision Care Program	None, except for prosthetic lenses from cataract surgery. Discount under Vision Care Program	None, except for prosthetic lenses from cataract surgery. Discount under Vision Care Program

*CIGNA HealthCare Network

¹Semi-private room and board, physician/surgeon charges, operating/delivery room and recovery room, general nursing and miscellaneous hospital services and supplies.

and Dependents Entitled to Medicare (cont.)

TRADITIONAL HMO		HMO WITH POINT OF SERVICE (POS) OPTION			
COMPANION HMO	CIGNA* HMO	COMPANION-CHOICES		CIGNA* POS	
Plan pays: Medicare deductible; \$210 coinsurance for days 61-90; \$420 coinsurance for days 91-150; 100% beyond 150 days	Plan pays 90% or unreimbursed Medicare-allowed expense after \$250 copay	<u>In-network</u> Plan pays: Medicare deductible; \$210 coinsurance for days 61-90; \$420 coinsurance for days 91-150; 100% beyond 150 days	<u>Out-of-network</u> Plan pays: Medicare deductible; \$210 coinsurance for days 61-90; \$420 coinsurance for days 91-150; 100% beyond 150 days	<u>In-network</u> Plan pays 90% or unreimbursed Medicare-allowed expense after Medicare after \$250 copay	<u>Out-of-network</u> Plan pays 60% or unreimbursed Medicare-allowed expense after \$250 copay
Plan pays \$105 for days 21-100; Plan pays 100% beyond 100 days	Plan pays 90% or unreimbursed Medicare-allowed expense, up to 180 days	Plan pays \$105 for days 21-100; Plan pays 100% beyond 100 days	Plan pays \$105 for days 21-100; Plan pays 100% beyond 100 days	Plan pays 90% or unreimbursed Medicare-allowed expense, up to 180 days	Plan pays 60% or unreimbursed Medicare-allowed expense, up to 180 days
Plan pays 80% if Medi-Cal approved You pay 20% and \$200 annual deductible \$5,000 annual max./ \$25,000 lifetime	Plan pays 100%	Plan pays 80% if Medi-Cal approved; You pay 20% and \$200 annual deductible \$5,000 annual max./ \$25,000 lifetime	Plan pays 80% if Medi-Cal approved; You pay 20% and \$200 annual deductible \$5,000 annual max./ \$25,000 lifetime	Plan pays 100%	Plan pays 60% You pay 40%
(Medicare pays 100% of covered charges)	Plan pays 100% or unreimbursed Medicare-allowed expense, up to 60 visits	(Medicare pays 100% of covered charges)	(Medicare pays 100% of covered charges)	Plan pays 100% or unreimbursed Medicare-allowed expense, up to 60 visits	Plan pays 60% or unreimbursed Medicare-allowed expense, up to 60 visits
(Medicare pays 100% of covered charges)	Plan pays 100% or unreimbursed Medicare-allowed expense	(Medicare pays 100% of covered charges)	(Medicare pays 100% of covered charges)	Plan pays 100% or unreimbursed Medicare-allowed expense	Plan pays 60% or unreimbursed Medicare-allowed expense
Plan pays 20% coinsurance	\$3,500 maximum Plan pays 100% or unreimbursed Medicare-allowed expense	Plan pays 20% coinsurance	Plan pays 20% coinsurance	\$3,500 maximum Plan pays 100% or unreimbursed Medicare-allowed expense	Covered in-network only
Plan pays 20% coinsurance	Plan pays 100% or unreimbursed Medicare-allowed expense	Plan pays 20% coinsurance	Plan pays 20% coinsurance	Plan pays 100% or unreimbursed Medicare-allowed expense	Covered in-network only
Plan pays 20% coinsurance. Otherwise, pays routine any age; 2 per year; \$15. Diagnostic: copay/ coinsurance	Plan pays 100% or unreimbursed Medicare-allowed expense after \$25 copay	Plan pays 20% coinsurance. Otherwise, pays routine any age; 2 per year; \$15. Diagnostic: copay/ coinsurance	Plan pays 20% coinsurance. Otherwise, covered in-network only	Plan pays 100% or unreimbursed Medicare-allowed expense after \$25 copay	Covered in-network only
Plan pays 20% coinsurance	Plan pays 90% or unreimbursed Medicare-allowed expense	Plan pays 20% coinsurance	Plan pays 20% coinsurance	Plan pays 90% or unreimbursed Medicare-allowed expense	Plan pays 60% or unreimbursed Medicare-allowed expense
One exam for glasses or contacts per year (\$45 copay for contacts exam). One pair glasses every other year (from designated selection)	Discount available through CIGNA Healthy Rewards program	One exam for glasses or contacts per year (\$45 copay for contacts exam). One pair glasses every other year (from designated selection)	Covered in-network only	Discount available through CIGNA Healthy Rewards program	

Your Dental Benefits in Retirement

This section explains briefly some highlights of the State Dental Plan and Dental Plus benefits. For a more complete overview of these benefits, refer to your *Insurance Benefits Guide*, which is available from your employer or from the Employee Insurance Program (EIP).

State Dental Plan

Your dental benefits are divided into four classes, outlined below. All benefits under the State Dental Plan are paid on the basis of the *Schedule of Dental Procedures and Allowable Charges*. Keep in mind that some services may not be covered under this plan. State Dental Plan premiums may be found on Pages 51-54.

State Dental Plan Covered Services

Class	Services Covered	Deductible	Percent Covered	Maximum Benefit
I Diagnostic and Preventive	Diagnostic and preventive procedures Cleaning and scaling of teeth Fluoride treatment Space maintainers (child) Emergency pain relief Radiographs (X-rays)	None	100% of allowable charges	\$1,000 per person each benefit year combined for Classes I, II and III
II Basic	Fillings Simple extractions Oral surgery Surgical extractions Preparation of mouth for dentures	\$25 annually combined for Classes II and III, Limited to three per family per year	80% of allowable charges	\$1,000 per person each benefit year combined for Classes I, II and III
III Prosthetics	Onlays Crowns Bridges Dentures Repair of Prosthetic Appliances	\$25 annually combined for Classes II and III, Limited to three per family per year	50% of allowable charges	\$1,000 per person each benefit year combined for Classes I, II and III
IV Orthodontia	Limited to covered children under age 19 Correction of malocclusion Consisting of: diagnosis (including models and radiographs) Active treatment (including necessary appliances)	None	50% of allowable charges	\$1,000 per lifetime for each covered child

To Continue Coverage in Retirement

You must file a Notice of Election (NOE) with EIP within 31 days of your retirement date or date of disability approval to continue your dental insurance coverage as a retiree. If you are not eligible for retiree insurance, you must request COBRA continuation coverage within 60 days of loss of coverage or notification of qualifying event, whichever is later. An open enrollment period for eligible retirees and their dependents is held every odd year (2003) with a coverage effective date of the following January 1 (2004). You also may enroll within 31 days of a special eligibility situation.

Predetermine Your Benefits for Expensive Treatment

You should predetermine your non-emergency treatment if you have estimated dental charges of \$500 or more. You and your dentist may fill out a claim form before any work is done, listing the services to be performed (course of treatment) and the associated charges. The completed claim form and X-rays should be mailed to Harrington Benefit Services (Harrington).

Harrington will send you and your dentist a Predetermination of Benefits estimate that indicates what part of the expenses will be covered. This estimate is not a guarantee of the actual charges or a guarantee of payment by Harrington. Your precertification is valid for one year from the date of the Predetermination of Benefits.

Filing Dental Claims

The easiest way to file a claim is to authorize your dentist to file a claim for you and to have your benefit payment sent directly to your dentist. Show your dental identification card and ask your dentist's office to file the claim for you. Be sure to sign the payment authorization block on the claim form. Harrington will pay your dentist's office directly. You are responsible for the difference between the benefit payment and the actual charge. You have 24 months from the date charges are incurred to submit a completed claim form to Harrington. Claims submitted more than 24 months after the charges are incurred will be denied.

If Your Dentist Will Not File Your Claim

If your dentist will not file a claim for you, file the claim yourself to Harrington by completing items 1-12 on a dental claim form and attaching an itemized bill showing the name of the dentist, the patient's name, the date, procedure and charge for each service. Claim forms are available from EIP and also may be downloaded from the EIP Web site at www.eip.state.sc.us.

If Your Claim Is Denied

Harrington will notify you if all or part of your claim or proposed treatment is denied. If you have questions about the decision, call Harrington Benefit Services for an explanation. If you don't believe the decision was fair you may ask Harrington to re-examine the denial. You may request in writing a review within six months after notification of the decision. If you wait too long, the decision may be considered final.

If the Denial Is Upheld

If you are not satisfied with Harrington's review decision, within 90 days you may request in writing that EIP review the decision. If the denial is upheld by EIP, you have 30 days to seek review in the circuit court pursuant to S.C. Code Ann. 1-23-380 (Law. Co-op. 1986 & Supp. 1995).

Dental Plus

Dental Plus is a supplemental dental program that provides a higher level of dental coverage for the same services covered under the State Dental Plan, except orthodontia (Class IV), at affordable rates. Under Dental Plus, maximum allowances are established at what a majority of dentists in South Carolina charge. Dental Plus premiums are paid entirely by you with no contribution from the state.

Dental Plus subscribers are required to carry the same level of coverage that they are enrolled in under the State Dental Plan. Your Dental Plus benefits are divided into classes, just like the State Dental Plan (see “State Dental Plan Covered Services” on Page 40). The combined annual maximum benefit for the State Dental Plan and Dental Plus for services in classes I, II and III is \$1,500 per covered person, compared to \$1,000 with the State Dental Plan alone. There are no additional deductibles or coinsurance under Dental Plus.

Dental Plus premiums may be found on Pages 51-54. The Dental Plus program is explained in more detail in your *Insurance Benefits Guide*.

To Enroll In or Continue Coverage in Retirement

You must file a Notice of Election (NOE) with EIP within 31 days of your retirement date or date of disability approval to enroll, or continue coverage, in Dental Plus as a retiree, just as you do with the State Dental Plan (explained earlier in this section).

Filing Dental Plus Claims

Since claims will continue to be filed with Harrington, you do not have any additional claim forms to fill out. Harrington will process your dental claims under the State Dental Plan first and then under Dental Plus (if you are enrolled in Dental Plus). See “Filing Dental Claims” on Page 41.

Life Insurance in Retirement

\$3,000 Basic Life Insurance

This benefit is given to you as an active employee and *ends* with retirement or termination. You may convert the \$3,000 Basic Life to an individual policy through The Hartford within 31 days of the date of coverage termination. Contact your benefits office or the Employee Insurance Program (EIP) for additional information and assistance.

South Carolina Retirement Systems Retiree Group Life Insurance

As a retiree, if you die and your last employer prior to retirement is covered by the Retiree Group Life Insurance program, a benefit based on your service credit will be paid by the South Carolina Retirement Systems to your beneficiaries as follows:

SCRS

10-19 years service credit = \$2,000

20-27 years service credit = \$4,000

28 or more years service credit = \$6,000

PORS

10-19 years service credit = \$2,000

20-24 years service credit = \$4,000

25 or more years service credit = \$6,000

Optional Life Insurance

Continuation of Optional Life

You are able to carry your Optional Life Insurance (administered by The Hartford) into retirement as follows:

- If you retired on or after January 1, 2001, you may continue your Optional Life coverage in \$10,000 increments up to the final face value of coverage until age 75. At age 70, coverage is reduced by 35 percent for active employees and retirees.
- You may convert your Optional Life coverage to an individual policy.

You must apply for continuation or conversion within 31 days of termination of coverage. Refer to your benefits office or EIP for assistance and fees. Premiums and reduced levels of coverage are on Page 55. Additional information about the Optional Life Insurance program is also available in your *Insurance Benefits Guide*.

Optional Life if You Become Disabled

If you become totally disabled while covered as an active employee, your life insurance will be continued for up to 12 months from your last day worked, provided:

- Your total disability began while you were covered by Optional Life Insurance;
- Your total disability began before you reached age 69; and
- The group Optional Life Insurance policy does not end.

Your premiums will be waived for up to 12 months from the last day worked as long as you are totally disabled. The 12-month waiver period begins the first of the month following your last day worked. In

order for your premiums to be waived, you must provide proof of disability to your benefits administrator within one year after the last day you were physically at work. If you return to work during the 12 months waiver period and work one full week, the premium waiver period should end; if you must leave employment again due to total disability, the 12 months waiver will start over from the last day you were physically at work.

When the waiver ends, you must file for continuation through The Hartford within 31 days of the waiver end date. Contact EIP for additional information.

Accidental Death and Dismemberment

The Accidental Death and Dismemberment benefits do not apply to retirees.

Premium Pretax Feature Not Available

Note that retired employees are not eligible for the Pretax Premium feature of the MoneyPlu\$ program.

Dependent Life Insurance

Any Dependent Life Insurance (administered by The Hartford) coverage you may have will terminate when you terminate active employment. Your covered dependent may convert the insurance coverage to an individual policy. The dependent must apply to The Hartford in writing within 31 days of the termination date of coverage and pay the required premiums. The policy will:

- Be issued without medical evidence of good health;
- Be on one of the life insurance policy forms;
- Be for no more than the amount for which he was last insured under this benefit;
- Contain no disability or supplementary benefit; and
- Become effective on the 32nd day after the group life insurance on the dependent's life terminates.

Additional information regarding the Dependent Life Insurance Program may be found in your *Insurance Benefits Guide*. Contact your benefits office or EIP for additional information and assistance.

Retirement and Long Term Disability Benefits

The general purpose of disability insurance is to protect an employee and the family against loss of income due to an extended injury or illness that prevents the employee from being able to work. In retirement, your income is guaranteed for your lifetime, and beyond, if you select a retirement annuity with a survivor option. When you terminate active employment, your Basic and Supplemental Long Term Disability will end.

Basic Long Term Disability

This benefit may not be continued or converted to an individual policy.

Supplemental Long Term Disability

Generally, you may not continue Supplemental Long Term Disability coverage in retirement. However, if you are retiring or leaving employment, but plan to work for an employer that does not have a supplemental long term disability program, contact the Employee Insurance Program for more information about continuing coverage through Standard Insurance Company, administrator for both the Basic and the Supplemental Long Term Disability programs.

Long Term Care in Retirement

Long term care refers to a wide range of personal health care services for people of all ages who suffer from chronic conditions. These individuals often need custodial care rather than skilled nursing home care. Custodial care is assistance with the activities of daily living such as eating, walking, dressing and transferring from a bed to a chair. This type of care can be provided in a nursing home, an adult daycare center or at home and is generally not covered under a health insurance plan.

Determine Your Need for Long Term Care Insurance

In estimating your own future long term care needs, consider your family medical history and whether you are at greater risk for certain health problems. Consider what long term care resources (i.e., nursing care facilities, adult daycare centers or home health care agencies) are available in your area. Review your financial resources to find out what you can do now to provide for your future needs. Determine the extent to which you are willing to rely on family and friends. Review the Long Term Care (LTC) insurance plan offered by the state benefits program. The program is explained in your *Insurance Benefits Guide*.

Long Term Care Services Already Covered

Medicare covers some home health and skilled nursing facility services; however, there are limits on the dollar amounts paid and the number of visits allowed. Neither the State Health Plan nor Medicare covers custodial care services, and to qualify for Medicaid, you must exhaust most of your personal assets and income.

Advantages of the Long Term Care Program

- You don't have to be confined to a nursing home to receive benefits. You receive care where it's most convenient for you—whether at home, in an adult daycare center or in a nursing facility.
- You choose your own coverage level in \$10 units—from \$40 to \$160 per day.
- You don't have to fill out a lot of forms, collect paperwork or submit receipts to receive benefits.
- If you die before using your benefits, your premiums may be returned to your beneficiary (depending on your status at the time you die) provided you enrolled as an active employee or as a spouse of an active employee. The amount returned is reduced by 10 percent per year beginning with the date of retirement or upon reaching age 65, whichever is later. For spouses and portable insureds, the reduction begins at age 65.
- You may apply to increase or reduce your coverage to keep pace with inflation or your own financial needs.

When Long Term Care Pays

You may receive LTC benefits if you are unable to carry out at least two activities of daily living, without continual help from another person, because of a chronic condition caused by illness or accident. If your claim is accepted, benefits payment will begin after a 90-day waiting period. The waiting period begins the day you can no longer perform at least two activities of daily living.

What Long Term Care Pays

This plan pays benefits ranging from \$40 to \$160 per day for care in a nursing facility. If you choose to

receive care in a home setting, the plan pays one-half of the amount of the nursing facility benefit. The amount you receive depends on how many \$10 coverage units you buy. If you purchase seven coverage units, your benefit will be \$70 per day in a nursing home or \$35 per day in a home setting.

What Long Term Care Does Not Pay

The plan will not pay for medical expenses due to:

- A pre-existing condition (any condition diagnosed or treated 90 days prior to the effective date of coverage);
- Treatment in government nursing facilities;
- Group policy duplications (any loss payable under the State Health Plan for hospital, convalescent or hospice facility confinements, or home health care);
- Mental illness (such as schizophrenia);
- War;
- Self-inflicted injuries;
- Hospital confinements;
- Treatment outside the United States;
- Workers' Compensation losses.

Continuing Coverage Into Retirement

If you are enrolled in LTC at the time you retire, you may continue your coverage. Each family member covered at the time of your retirement may continue coverage as well. You must elect to continue LTC coverage within 31 days of the date coverage would otherwise terminate.

Enrolling in Coverage at Retirement

You and/or your spouse may enroll in LTC at any time by providing medical evidence of good health. You should request information and an application from Aetna, the administrator of the LTC program, or the Employee Insurance Program (EIP). If you are approved for coverage, Aetna will send confirmation to you and to EIP.

Premiums in Retirement

You pay the entire cost of LTC coverage for yourself and your spouse (if applicable). If you and your spouse choose to participate in the plan, your premiums will be based on your age at the time of your application (some exceptions may apply). Premiums may be found on Pages 56-57. EIP will deduct your premiums from your monthly SCRS annuity as long as your premiums are not more than your pension benefit. If your pension benefit is not sufficient to cover the entire amount of your health, dental and LTC premiums, EIP will bill you directly for all premiums. You may request in writing to have your premiums drafted automatically from your bank account. Local subdivision retirees will be billed by the local subdivision.

MoneyPlu\$ Not Available in Retirement

MoneyPlu\$, the program that offers the Medical Spending Account and Dependent Care Spending Account and allows active employees to pay their insurance premiums pretax, is not available to you in retirement.

Vision Care Program in Retirement

Regardless of whether you are enrolled in the State Health Plan or a health maintenance organization or not, as a retiree, you may take advantage of the Vision Care Program and receive discounted services. Participating ophthalmologists and optometrists throughout the state have agreed to charge no more than \$50 for a routine, comprehensive eye examination. If you are fitted for contact lenses, you may have to pay additional charges. The fitting of contact lenses usually requires additional services. Participating providers, including opticians, have also agreed to a 20 percent discount on all eyewear. The discount does not apply to disposable contact lenses.

Participating providers are listed in the *Vision Care Program Provider Directory* available from your benefits office or on the Employee Insurance Program's Web site at www.eip.state.sc.us.

Returning to Work

Since the earnings limitation for service retirees of the South Carolina Retirement Systems has increased and the earnings limitation has been suspended for teachers in critical needs areas, more individuals are electing to receive their monthly retirement benefits while continuing to work. In addition, people who are already retired are returning to work.

Deciding on Coverage

If you are covered under the state retiree group and return to active employment in a permanent, full-time position, you must decide whether you want to be covered under the active group employee benefits or continue your retiree group benefits. You cannot be covered under both. If you prefer to continue your retiree group insurance benefits, you must complete and sign a refusal form for active benefits.

Keep in mind that if you refuse to enroll as an active employee, you are also refusing benefits that are available to active employees only:

- \$3,000 Basic Life benefit;
- Basic and Supplemental Long Term Disability coverage;
- Dependent Life Insurance;
- Optional Life Insurance;
- MoneyPlu\$ benefits.

If You Are Entitled to Medicare

If you are entitled to Medicare and return to active employee benefits, Medicare will become the secondary payer to the state group active coverage. Therefore, you must notify Social Security that you are covered under the active group coverage, and Medicare Part B may be dropped while you are covered as an active employee. When you leave active employment and your active group coverage is terminated, you will be eligible to return to retiree group coverage. You must file an enrollment form to return to the state retiree group. In addition, you should notify Social Security that you are no longer covered under an active group so that you can re-enroll for Medicare Part B.

TERI Program

How TERI Works

The Teacher Employee Retention Incentive (TERI) program with the South Carolina Retirement Systems (SCRS) allows you to retire and begin accumulating your retirement annuity on a deferred basis without terminating your employment. By participating in the program, you may defer your retirement benefit for up to five years. Your monthly retirement annuity is deferred and accumulated in your TERI account. Upon termination of employment or at the end of your TERI period, whichever occurs first, you may receive the balance in your TERI account in either a taxable, lump-sum distribution or through

a rollover into a qualified retirement plan. You will then begin receiving your monthly service retirement benefit plus any cost-of-living increases. No interest is paid on annuity benefits accumulated in your TERI account.

As a TERI participant you are technically retired. You do not make contributions to your SCRS account, nor do you earn service credit. You are also ineligible to receive active SCRS Group Life Insurance benefits or SCRS disability retirement benefits. During the TERI period, you are exempt from the service retirement earnings limitation. If you continue to work for a covered employer after your TERI period ends, you will be subject to the service retirement earnings limitation. For more information on the TERI program, contact SCRS.

How TERI Affects Your Insurance Coverage

If you are participating under the TERI program, you continue your insurance coverage under the active group insurance program as long as you are eligible. At the end of your TERI period, you will need to file a Notice of Election form within 31 days for continuation of coverage as a retiree.

Retiree Outreach Services

There are health, financial, legal and lifestyle concerns unique to retirees, and we can help. The Employee Insurance Program (EIP) offers workshops for retirees that address subjects like: diet, nutrition and healthy habits in retirement; investing, wills and estate planning; financial planning; advanced directives; long-term care alternatives; fraud and scams; home security; and senior resources. Contact EIP for details.

2003 Regular Retiree (Employer-Funded Benefits) Health Plan Monthly Premiums¹

(Retiree entitled to Medicare/spouse entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL ²	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	CIGNA POS
Retiree	N/A	\$ 35.74	\$ 53.74	\$ 45.54	\$55.14	N/A	\$ 53.56	\$ 70.73
Retiree/spouse	N/A	\$124.44	\$160.44	\$149.27	\$170.48	N/A	\$166.98	\$204.91
Retiree/children	N/A	\$ 72.76	\$ 90.76	\$124.69	\$141.42	N/A	\$138.66	\$168.59
Full family	N/A	\$161.46	\$197.46	\$288.46	\$317.44	N/A	\$312.66	\$364.50

(Retiree entitled to Medicare/spouse not entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL ²	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	CIGNA POS
Retiree/spouse	N/A	\$136.78	\$154.78	\$149.27	\$170.48	N/A	\$166.98	\$204.91
Full family	N/A	\$181.88	\$199.88	\$288.46	\$317.44	N/A	\$312.66	\$364.50

(Retiree not entitled to Medicare/spouse entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL ²	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	CIGNA POS
Retiree/spouse	N/A	\$139.16	\$157.16	\$149.27	\$170.48	N/A	\$166.98	\$204.91
Full family	N/A	\$176.18	\$194.18	\$288.46	\$317.44	N/A	\$312.66	\$364.50

(Retiree not entitled to Medicare/spouse not entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL ²	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	CIGNA POS
Retiree	\$ 47.44	\$ 50.46	N/A	\$ 45.54	\$ 55.14	\$ 49.90	\$ 53.56	\$ 70.73
Retiree/spouse	\$132.04	\$151.50	N/A	\$149.27	\$170.48	\$146.64	\$166.98	\$204.91
Retiree/children	\$ 77.06	\$ 87.48	N/A	\$124.69	\$141.42	\$106.78	\$138.66	\$168.59
Full family	\$168.12	\$196.60	N/A	\$288.46	\$317.44	\$234.90	\$312.66	\$364.50

(Retiree not entitled to Medicare/spouse not entitled to Medicare/one or more children entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL ²	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	CIGNA POS
Retiree/children	N/A	\$ 87.48	\$105.48	\$124.69	\$141.42	N/A	\$138.66	\$168.59
Full family	N/A	\$196.60	\$214.60	\$288.46	\$317.44	N/A	\$312.66	\$364.50

¹Rates for local subdivisions may vary. To verify your rates, contact your benefits office.

²If the Medicare Supplemental plan is elected, claims for covered subscribers not entitled to Medicare will be based on the Standard plan provisions.

2003 Regular Retiree (Employer-Funded Benefits) Dental Plan Monthly Premiums

	Dental	Dental Plus
Subscriber Only	\$0.00	\$15.50
Subscriber/Spouse	\$7.64	\$29.34
Subscriber/Child	\$13.72	\$32.02
Full Family	\$21.34	\$45.86

2003 Retiree (5-10 year, buy-in & age 55/25 year) Health Plan Monthly Premiums¹

(Retiree entitled to Medicare/spouse entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL ²	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	CIGNA POS
Retiree	N/A	\$242.44	\$260.44	\$252.24	\$261.84	N/A	\$260.26	\$277.43
Retiree/spouse	N/A	\$528.56	\$564.56	\$553.39	\$574.60	N/A	\$571.10	\$609.03
Retiree/children	N/A	\$385.36	\$403.36	\$437.29	\$454.02	N/A	\$451.26	\$481.19
Full family	N/A	\$628.18	\$664.18	\$755.18	\$784.16	N/A	\$779.38	\$831.22

(Retiree entitled to Medicare/spouse not entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL ²	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	CIGNA POS
Retiree/spouse	N/A	\$540.90	\$558.90	\$553.39	\$574.60	N/A	\$571.10	\$609.03
Full family	N/A	\$648.60	\$666.60	\$755.18	\$784.16	N/A	\$779.38	\$831.22

(Retiree not entitled to Medicare/spouse entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL ²	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	CIGNA POS
Retiree/spouse	N/A	\$543.28	\$561.28	\$553.39	\$574.60	N/A	\$571.10	\$609.03
Full family	N/A	\$642.90	\$660.90	\$755.18	\$784.16	N/A	\$779.38	\$831.22

(Retiree not entitled to Medicare/spouse not entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL ²	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	CIGNA POS
Retiree	\$254.14	\$257.16	N/A	\$252.24	\$261.84	\$256.60	\$260.26	\$277.43
Retiree/spouse	\$536.16	\$555.62	N/A	\$553.39	\$574.60	\$550.76	\$571.10	\$609.03
Retiree/children	\$389.66	\$400.08	N/A	\$437.29	\$454.02	\$419.38	\$451.26	\$481.19
Full family	\$634.84	\$663.32	N/A	\$755.18	\$784.16	\$701.62	\$779.38	\$831.22

(Retiree not entitled to Medicare/spouse not entitled to Medicare/one or more children entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL ²	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	CIGNA POS
Retiree/children	N/A	\$400.08	\$418.08	\$437.29	\$454.02	N/A	\$451.26	\$481.19
Full family	N/A	\$663.32	\$681.32	\$755.18	\$784.16	N/A	\$779.38	\$831.22

¹Rates for local subdivisions may vary. To verify your rates, contact your benefits office.

²If the Medicare Supplemental plan is elected, claims for covered subscribers not entitled to Medicare will be based on the Standard plan provisions.

2003 Retiree (5-10 year, buy-in & age 55/25 year) Dental Plan Monthly Premiums

	Dental	Dental Plus
Subscriber Only	\$11.71	\$15.50
Subscriber/Spouse	\$19.35	\$29.34
Subscriber/Child	\$25.43	\$32.02
Full Family	\$33.05	\$45.86

2003 Survivor Health Plan Monthly Premiums¹

(Spouse entitled to Medicare/children entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL ²	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	CIGNA POS
Spouse	N/A	\$242.44	\$260.44	\$252.24	\$261.84	N/A	\$260.26	\$277.43
Spouse/children	N/A	\$385.36	\$421.36	\$437.29	\$454.02	N/A	\$451.26	\$481.19
Children only	N/A	\$142.92	\$160.92 ³	\$185.05	\$192.18	N/A	\$191.00	\$203.76

(Spouse entitled to Medicare/children not entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL ²	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	CIGNA POS
Spouse	N/A	\$242.44	\$260.44	\$252.24	\$261.84	N/A	\$260.26	\$277.43
Spouse/children	N/A	\$385.36	\$403.36	\$437.29	\$454.02	N/A	\$451.26	\$481.19
Children only	\$135.52	\$142.92	N/A	\$185.05	\$192.18	\$162.78	\$191.00	\$203.76

(Spouse not entitled to Medicare/children entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL ²	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	CIGNA POS
Spouse	\$254.14	\$257.16	N/A	\$252.24	\$261.84	\$256.60	\$260.26	\$277.43
Spouse/children	N/A	\$400.08	\$418.08 ³	\$437.29	\$454.02	N/A	\$451.26	\$481.19
Children only	N/A	\$142.92	\$160.92 ³	\$185.05	\$192.18	N/A	\$191.00	\$203.76

(Spouse not entitled to Medicare/children not entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL ²	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	CIGNA POS
Spouse	\$254.14	\$257.16	N/A	\$252.24	\$261.84	\$256.60	\$260.26	\$277.43
Spouse/children	\$389.66	\$400.08	N/A	\$437.29	\$454.02	\$419.38	\$451.26	\$481.19
Children only	\$135.52	\$142.92	N/A	\$185.05	\$192.18	\$162.78	\$191.00	\$203.76

¹Plan premiums for spouses and dependents will be waived for one year after the death of the funded employee or retiree for those covered as dependents under the Plan at the time of death.

²If the Medicare Supplemental plan is elected, claims for covered subscribers not entitled to Medicare will be based on the Standard plan provisions.

³This premium applies only if one or more children are entitled to Medicare.

2003 Survivor Dental Plan Monthly Premiums

	Dental	Dental Plus
Survivor Spouse Only	\$11.71	\$15.50
Survivor Spouse and Children	\$25.43	\$32.02
Survivor Children Only	\$13.72	\$16.52

2003 COBRA Health Plan Monthly Premiums

18 and 36 months

	ECONOMY	STANDARD	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	CIGNA POS
Subscriber only	\$259.22	\$262.30	\$257.28	\$267.08	\$261.73	\$265.47	\$282.98
Subscriber/spouse	\$546.88	\$566.73	\$564.46	\$586.09	\$561.78	\$582.52	\$621.21
Subscriber/children	\$397.45	\$408.08	\$446.04	\$463.10	\$427.77	\$460.29	\$490.81
Family	\$647.54	\$676.59	\$770.28	\$799.84	\$715.65	\$794.97	\$847.84
Children (age 18 and under)	\$138.23	\$145.78	\$188.75	\$196.02	\$166.04	\$194.82	\$207.84

29 months (These rates go into effect in the 19th month of coverage for 29-month COBRA subscribers.)

	ECONOMY	STANDARD	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	CIGNA POS
Subscriber only	\$381.21	\$385.74	\$ 378.36	\$ 392.76	\$ 384.90	\$ 390.39	\$ 416.15
Subscriber/spouse	\$804.24	\$833.43	\$ 830.09	\$ 861.90	\$ 826.14	\$ 856.65	\$ 913.55
Subscriber/children	\$584.49	\$600.12	\$ 655.94	\$ 681.03	\$ 629.07	\$ 676.89	\$ 721.79
Family	\$952.26	\$994.98	\$1,132.77	\$1,176.24	\$1,052.43	\$1,169.07	\$1,246.83
Children (age 18 and under)	\$203.28	\$214.38	\$ 277.58	\$ 288.27	\$ 244.17	\$ 286.50	\$ 305.64

2003 COBRA Dental Plan Monthly Premiums

18, 29 and 36 months

	Dental	Dental Plus
Subscriber Only	\$11.94	\$15.81
Subscriber/Spouse	\$19.74	\$29.93
Subscriber/Child	\$25.94	\$32.66
Full Family	\$33.71	\$46.78
Children	\$13.99	\$16.85

2003 Optional Life Insurance Premiums

2003 OPTIONAL LIFE PORTABILITY INSURANCE RATES										
	< 35	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	
\$10,000	\$ 0.82	\$ 0.96	\$ 1.52	\$ 2.10	\$ 3.26	\$ 5.12	\$ 7.84	\$ 11.70	\$6,500	\$ 12.30
\$20,000	\$ 1.64	\$ 1.92	\$ 3.04	\$ 4.20	\$ 6.52	\$ 10.24	\$ 15.68	\$ 23.38	\$13,000	\$ 24.58
\$30,000	\$ 2.46	\$ 2.88	\$ 4.56	\$ 6.30	\$ 9.78	\$ 15.36	\$ 23.52	\$ 35.08	\$19,500	\$ 36.88
\$40,000	\$ 3.28	\$ 3.84	\$ 6.08	\$ 8.40	\$ 13.04	\$ 20.48	\$ 31.36	\$ 46.76	\$26,000	\$ 49.16
\$50,000	\$ 4.10	\$ 4.80	\$ 7.60	\$ 10.50	\$ 16.30	\$ 25.60	\$ 39.20	\$ 58.46	\$32,500	\$ 61.46
\$60,000	\$ 4.92	\$ 5.76	\$ 9.12	\$ 12.60	\$ 19.56	\$ 30.72	\$ 47.04	\$ 70.14	\$39,000	\$ 73.74
\$70,000	\$ 5.74	\$ 6.72	\$ 10.64	\$ 14.70	\$ 22.82	\$ 35.84	\$ 54.88	\$ 81.84	\$45,500	\$ 86.04
\$80,000	\$ 6.56	\$ 7.68	\$ 12.16	\$ 16.80	\$ 26.08	\$ 40.96	\$ 62.72	\$ 93.52	\$52,000	\$ 98.34
\$90,000	\$ 7.38	\$ 8.64	\$ 13.68	\$ 18.90	\$ 29.34	\$ 46.08	\$ 70.56	\$ 105.22	\$58,500	\$110.62
\$100,000	\$ 8.20	\$ 9.60	\$ 15.20	\$ 21.00	\$ 32.60	\$ 51.20	\$ 78.40	\$ 116.90	\$65,000	\$122.92
\$110,000	\$ 9.02	\$ 10.56	\$ 16.72	\$ 23.10	\$ 35.86	\$ 56.32	\$ 86.24	\$ 128.60	\$71,500	\$135.20
\$120,000	\$ 9.84	\$ 11.52	\$ 18.24	\$ 25.20	\$ 39.12	\$ 61.44	\$ 94.08	\$ 140.28	\$78,000	\$147.50
\$130,000	\$ 10.66	\$ 12.48	\$ 19.76	\$ 27.30	\$ 42.38	\$ 66.56	\$ 101.92	\$ 151.98	\$84,500	\$159.78
\$140,000	\$ 11.48	\$ 13.44	\$ 21.28	\$ 29.40	\$ 45.64	\$ 71.68	\$ 109.76	\$ 163.66	\$91,000	\$172.08
\$150,000	\$ 12.30	\$ 14.40	\$ 22.80	\$ 31.50	\$ 48.90	\$ 76.80	\$ 117.60	\$ 175.36	\$97,500	\$184.38
\$160,000	\$ 13.12	\$ 15.36	\$ 24.32	\$ 33.60	\$ 52.16	\$ 81.92	\$ 125.44	\$ 187.04	\$104,000	\$196.66
\$170,000	\$ 13.94	\$ 16.32	\$ 25.84	\$ 35.70	\$ 55.42	\$ 87.04	\$ 133.28	\$ 198.74	\$110,500	\$208.96
\$180,000	\$ 14.76	\$ 17.28	\$ 27.36	\$ 37.80	\$ 58.68	\$ 92.16	\$ 141.12	\$ 210.42	\$117,000	\$221.24
\$190,000	\$ 15.58	\$ 18.24	\$ 28.88	\$ 39.90	\$ 61.94	\$ 97.28	\$ 148.96	\$ 222.12	\$123,500	\$233.54
\$200,000	\$ 16.40	\$ 19.20	\$ 30.40	\$ 42.00	\$ 65.20	\$ 102.40	\$ 156.80	\$ 233.80	\$130,000	\$245.84
\$210,000	\$ 17.22	\$ 20.16	\$ 31.92	\$ 44.10	\$ 68.46	\$ 107.52	\$ 164.64	\$ 245.50	\$136,500	\$258.12
\$220,000	\$ 18.04	\$ 21.12	\$ 33.44	\$ 46.20	\$ 71.72	\$ 112.64	\$ 172.48	\$ 257.18	\$143,000	\$270.42
\$230,000	\$ 18.86	\$ 22.08	\$ 34.96	\$ 48.30	\$ 74.98	\$ 117.76	\$ 180.32	\$ 268.88	\$149,500	\$282.70
\$240,000	\$ 19.68	\$ 23.04	\$ 36.48	\$ 50.40	\$ 78.24	\$ 122.88	\$ 188.16	\$ 280.56	\$156,000	\$295.00
\$250,000	\$ 20.50	\$ 24.00	\$ 38.00	\$ 52.50	\$ 81.50	\$ 128.00	\$ 196.00	\$ 292.26	\$162,500	\$307.28
\$260,000	\$ 21.32	\$ 24.96	\$ 39.52	\$ 54.60	\$ 84.76	\$ 133.12	\$ 203.84	\$ 303.94	\$169,000	\$319.58
\$270,000	\$ 22.14	\$ 25.92	\$ 41.04	\$ 56.70	\$ 88.02	\$ 138.24	\$ 211.68	\$ 315.64	\$175,500	\$331.88
\$280,000	\$ 22.96	\$ 26.88	\$ 42.56	\$ 58.80	\$ 91.28	\$ 143.36	\$ 219.52	\$ 327.32	\$182,000	\$344.16
\$290,000	\$ 23.78	\$ 27.84	\$ 44.08	\$ 60.90	\$ 94.54	\$ 148.48	\$ 227.36	\$ 339.02	\$188,500	\$356.46
\$300,000	\$ 24.60	\$ 28.80	\$ 45.60	\$ 63.00	\$ 97.80	\$ 153.60	\$ 235.20	\$ 350.70	\$195,000	\$368.74
\$310,000	\$ 25.42	\$ 29.76	\$ 47.12	\$ 65.10	\$ 101.06	\$ 158.72	\$ 243.04	\$ 362.40	\$201,500	\$381.04
\$320,000	\$ 26.24	\$ 30.72	\$ 48.64	\$ 67.20	\$ 104.32	\$ 163.84	\$ 250.88	\$ 374.08	\$208,000	\$393.32
\$330,000	\$ 27.06	\$ 31.68	\$ 50.16	\$ 69.30	\$ 107.58	\$ 168.96	\$ 258.72	\$ 385.76	\$214,500	\$405.62
\$340,000	\$ 27.88	\$ 32.64	\$ 51.68	\$ 71.40	\$ 110.84	\$ 174.08	\$ 266.56	\$ 397.46	\$221,000	\$417.90
\$350,000	\$ 28.70	\$ 33.60	\$ 53.20	\$ 73.50	\$ 114.10	\$ 179.20	\$ 274.40	\$ 409.14	\$227,500	\$430.20
\$360,000	\$ 29.52	\$ 34.56	\$ 54.72	\$ 75.60	\$ 117.36	\$ 184.32	\$ 282.24	\$ 420.84	\$234,000	\$442.48
\$370,000	\$ 30.34	\$ 35.52	\$ 56.24	\$ 77.70	\$ 120.62	\$ 189.44	\$ 290.08	\$ 432.52	\$240,500	\$454.78
\$380,000	\$ 31.16	\$ 36.48	\$ 57.76	\$ 79.80	\$ 123.88	\$ 194.56	\$ 297.92	\$ 444.22	\$247,000	\$467.08
\$390,000	\$ 31.98	\$ 37.44	\$ 59.28	\$ 81.90	\$ 127.14	\$ 199.68	\$ 305.76	\$ 455.90	\$253,500	\$479.36
\$400,000	\$ 32.80	\$ 38.40	\$ 60.80	\$ 84.00	\$ 130.40	\$ 204.80	\$ 313.60	\$ 467.60	\$260,000	\$491.66

*You may elect to pay The Hartford quarterly, semi-annually or annually. A \$5 administration fee per billing will apply.

2003 Long Term Care Insurance Premiums

(Continuing Coverage From Active Employment Into Retirement)

2003 Long Term Care Insurance Rates Retiree Rates for Active Coverage Retained After Retirement Retirees and Spouses

Note: These rates apply to:

1. Coverage purchased by employee or spouse before the employee retired and retained after retirement.
2. Coverage purchased by the retiree or spouse after retirement.

Age	Per \$1 Benefit Amount	Per \$10 Benefit Amount
20	.050	.50
21	.054	.54
22	.056	.56
23	.060	.60
24	.064	.64
25	.068	.68
26	.070	.70
27	.076	.76
28	.080	.80
29	.086	.86
30	.090	.90
31	.096	.96
32	.104	1.04
33	.110	1.10
34	.116	1.16
35	.124	1.24
36	.132	1.32
37	.142	1.42
38	.150	1.50
39	.162	1.62
40	.174	1.74
41	.186	1.86
42	.196	1.96
43	.212	2.12

Age	Per \$1 Benefit Amount	Per \$10 Benefit Amount
44	.226	2.26
45	.242	2.42
46	.258	2.58
47	.278	2.78
48	.296	2.96
49	.314	3.14
50	.336	3.36
51	.358	3.58
52	.382	3.82
53	.408	4.08
54	.440	4.40
55	.476	4.76
56	.512	5.12
57	.552	5.52
58	.594	5.94
59	.638	6.38
60	.684	6.84
61	.734	7.34
62	.788	7.88
63	.844	8.44
64	.906	9.06
65	.972	9.72
66	1.056	10.56
67	1.150	11.50

Age	Per \$1 Benefit Amount	Per \$10 Benefit Amount
68	1.252	12.52
69	1.368	13.68
70	1.494	14.94
71	1.632	16.32
72	1.788	17.88
73	1.958	19.58
74	2.148	21.48
75	2.360	23.60
76	2.596	25.96
77	2.852	28.52
78	3.134	31.34
79	3.424	34.24
80	3.716	37.16
81	4.002	40.02
82	4.274	42.74
83	4.530	45.30
84	4.776	47.76
85	5.018	50.18
86	5.250	52.50
87	5.474	54.74
88	5.690	56.90
89	5.918	59.18
90+	6.158	61.58

2003 Long Term Care Insurance Premiums

(Enrolling in Coverage at Retirement if Not Covered During Employment)

2003 Long Term Care Insurance Rates Retirees, Spouses, Parents and Parents-in-Law

Note: These rates apply to:

1. Coverage purchased by retirees and spouses after the employee retires, when first coverage is purchased after retirement.
2. Coverage purchased by parents and parents-in-law at any time.

Age	Per \$1 Benefit Amount	Per \$10 Benefit Amount
20	.044	.44
21	.048	.48
22	.051	.51
23	.054	.54
24	.058	.58
25	.060	.60
26	.064	.64
27	.068	.68
28	.072	.72
29	.076	.76
30	.081	.81
31	.087	.87
32	.092	.92
33	.097	.97
34	.103	1.03
35	.111	1.11
36	.117	1.17
37	.124	1.24
38	.132	1.32
39	.142	1.42
40	.152	1.52
41	.162	1.62
42	.174	1.74
43	.186	1.86

Age	Per \$1 Benefit Amount	Per \$10 Benefit Amount
44	.198	1.98
45	.213	2.13
46	.226	2.26
47	.242	2.42
48	.260	2.60
49	.277	2.77
50	.296	2.96
51	.316	3.16
52	.339	3.39
53	.365	3.65
54	.395	3.95
55	.427	4.27
56	.462	4.62
57	.500	5.00
58	.540	5.40
59	.584	5.84
60	.630	6.30
61	.681	6.81
62	.735	7.35
63	.795	7.95
64	.860	8.60
65	.930	9.30
66	1.007	10.07
67	1.091	10.91

Age	Per \$1 Benefit Amount	Per \$10 Benefit Amount
68	1.182	11.82
69	1.280	12.80
70	1.387	13.87
71	1.503	15.03
72	1.629	16.29
73	1.765	17.65
74	1.915	19.15
75	2.079	20.79
76	2.256	22.56
77	2.446	24.46
78	2.648	26.48
79	2.847	28.47
80	3.038	30.38
81	3.214	32.14
82	3.370	33.70
83	3.504	35.04
84	3.624	36.24
85	3.733	37.33
86	3.830	38.30
87	3.917	39.17
88	3.992	39.92
89	4.065	40.65
90+	4.138	41.38

Who to Contact for More Information

Aetna

Long Term Care

151 Farmington Avenue

Hartford, CT 06156

800-537-8521

860-952-2024 (FAX)

www.aetna.com/group/southcarolina

CIGNA HealthCare

CIGNA HealthCare Network HMO and CIGNA HealthCare Network POS

Post Office Box 5200

Scranton, PA 18505-5200

800-244-6224

www.cigna.com

APS Healthcare, Inc.

State Health Plan Mental Health and

Substance Abuse services

Claims, State of South Carolina

Post Office Box 1307

Rockville, MD 20849

800-221-8699

888-897-8931 (FAX)

www.apshealthcare.com

Companion HealthCare

Companion HMO and Companion CHOICES POS

Member Services

Post Office Box 6170

AX-435

Columbia, SC 29260-6170

800-868-2528 (nationwide)

803-786-8476 (Columbia)

www.CompanionHealthCare.com

BlueCross BlueShield of South Carolina

State Health Plan claims

Post Office Box 100605

Columbia, SC 29260-0605

800-868-2520 (nationwide)

803-736-1576 (Columbia)

800-222-4243 (TDD)

803-699-7675 (FAX)

www.southcarolinablues.com

Natural Blue: www.healthyroads.com

Employee Insurance Program

mailing address: Post Office Box 11661

Columbia, SC 29211-1661

street address: 1201 Main Street, Suite 300

Columbia, SC 29201

Customer Services

888-260-9430 (nationwide)

803-734-0678 (Columbia)

803-734-1696 (retiree billing)

803-737-0825 (FAX)

www.eip.state.sc.us

Medi-Call

*Precertification and Maternity Management benefit
(BlueCross BlueShield of South Carolina)*

AF 330

I-20 Alpine Road

Columbia, SC 29219

800-925-9724 (nationwide)

803-699-3337 (Columbia)

800-222-4243 (TDD)

803-264-0183 (FAX)

Fringe Benefits Management Company

MoneyPlu\$

mailing address:

Post Office Box 1878

Tallahassee, FL 32302-1878

street address:

3101 Sessions Road

Tallahassee, FL 32303

800-342-8017 (nationwide)

800-865-3262 (automated information)

850-425-4608 (claims FAX)

850-425-6220 (other FAX)

www.fbmc-benefits.com

Harrington Benefit Services, Inc.

State Dental Plan and Dental Plus

Post Office Box 268902

Oklahoma City, OK 73126-8902

800-848-2025

405-499-4869 (FAX)

800-824-1716 (TDD)

www.harringtonbenefits.com

The Hartford

Basic Life, Optional Life and Dependent Life

Benefit Management Services

Post Office Box 2999

Hartford, CT 06104-2999

888-563-1124 (death claims)

800-331-7234 (evidence of insurability)

888-803-7346, ext. 3648 (retiree enrollment/claims)

800-548-5157 (conversion)

Medco Health Solutions, Inc.

State Health Plan Prescription Drug Program

Medco Health Prescriptions

Post Office Box 2277

Lee's Summit, MO 64063-2277

800-711-3450 (nationwide)

800-759-1089 (TDD)

www.medcohealth.com

Medicare

1-800-MEDICARE (1-800-633-4227)

TTY (1-877-486-2048)

www.medicare.gov

MUSC Options

MUSC Options POS

Post Office Box 6170

AX-435

Columbia, SC 29260-6170

800-821-3023

www.CompanionHealthCare.com

Social Security Administration

800-772-1213 (nationwide)

800-325-0778 (TTY)

www.ssa.gov

State Health Plan Prevention Partners

mailing address:

Post Office Box 11661

Columbia, SC 29201

street address:

1201 Main Street, Suite 830

Columbia, SC 29201

888-260-9430 (nationwide)

803-737-3820 (Columbia)

www.eip.state.sc.us

South Carolina Retirement Systems

mailing address:

Post Office Box 11960

Columbia, SC 29211-1960

street address:

Gressette-Collins Building

202 Arbor Lake Drive

Columbia, SC 29223

800-868-9002 (toll-free in S.C.)

803-737-6800 (Columbia)

www.scrs.state.sc.us

Standard Insurance Co.

Basic Long Term Disability and Supplemental Long Term Disability

mailing address:

Post Office Box 2800

Portland, OR 97208

street address:

900 SW Fifth Avenue

Portland, OR 97204

800-628-9696 (customer service)

800-843-7979 (medical evidence)

800-437-0961 (FAX)

www.standard.com

TRICARE

Military Health Plan

800-444-5445 (Southeast region)

www.tricare.osd.mil

Glossary of Terms

The following is a ready reference of general insurance terms as well as those terms that pertain to the state's benefits programs.

Actively at Work

Employees are considered actively at work on an employer's scheduled work day if they are performing in the usual manner all of the regular duties of their work on a full-time basis on that day, whether at their usual place of work or at another place if required to travel. Employees are also considered actively at work on a paid vacation day or on a day that is not one of the employer's scheduled work days only if they were actively at work on the preceding scheduled work days.

Allowable Charge

The maximum amount a health or dental plan (such as the State Health Plan, an HMO or Medicare, the State Dental Plan, etc.) will pay for a covered expense. Network providers and facilities are those who have agreed to accept the allowable charge for covered services under the plan.

Annual Enrollment

A period each year during which eligible employees and retirees may change health plans only (State Health Plan (SHP) Economy to Standard, Standard to Economy, SHP to an HMO, HMO to SHP or HMO to another HMO). No other changes are allowed. Health plan changes are allowed each annual enrollment period with the exception of retirees changing to or from the Medicare Supplemental plan. See also *Open Enrollment*.

Assigned Claim

A claim for which the provider accepts Medicare's allowable charge for a covered expense.

Balance Billing

The practice of billing patients for the difference for charges that exceed the amount that an insurance

plan will allow for a particular service. Network providers and facilities are those who have agreed to accept the allowable charge for covered services under the plan.

See also *Pay-the-Difference*.

Basic Salary

The actual amount for which an employee is compensated by the employer per year, including merit and longevity increases. Basic salary does not include commissions, annuities, bonuses, overtime or incentive pay. For a teacher, basic salary does not include compensation for summer school.

Changing Plans

Changes from one health plan to another may be made during an *annual* enrollment period or an *open* enrollment period. Exception: changes to or from the Medicare Supplemental plan may only be made within 31 days of entitlement to Medicare or during an open enrollment period.

Child

See *Dependent Child*.

COBRA

Consolidated Omnibus Budget Reconciliation Act of 1985. This Act requires that continuation of group insurance coverage be offered to covered persons who lose health or dental coverage due to a qualifying event as defined in the Act. See also *Qualifying Event*.

Coinsurance

Coinsurance is the percentage of covered medical expenses a subscriber must pay in conjunction with the percentage paid by an insurance plan for covered expenses. These amounts are called coinsurance

because both the subscriber and the insurance plan share the cost of health care expenses.

Coinsurance Maximum

The coinsurance maximum is the most money a subscriber would pay in coinsurance each year before the insurance plan begins to pay 100 percent of the allowable charge for covered expenses. This does not apply to the Medicare Supplemental plan.

Coordination of Benefits

A system to eliminate duplication of benefits when a person is covered under more than one group plan. Benefits under the two plans are usually limited to no more than 100 percent of the claim.

Copayment

A copayment is a fixed dollar amount a subscriber must pay in addition to what is paid by the subscriber's insurance plan for covered expenses. These amounts are called copayments because both the subscriber and the insurance plan share the cost of health care expenses.

Copayment Maximum

The most money a subscriber would pay each year before the insurance plan begins to pay the entire allowable charge for covered expenses.

Covered Expense

An expense that is provided for by the insurance plan. A covered expense is a charge that is not excluded by any term, condition, limitation or exclusion of the plan.

Covered Person

A person (employee, retiree, survivor, COBRA participant, spouse or dependent) who has met the eligibility requirements and is enrolled in an insurance plan.

Creditable Coverage

Prior coverage under a group health plan or insurance coverage or health benefits provided as described or defined by the Health Insurance Portabil-

ity and Accountability Act (HIPAA) of 1996. Proof of creditable coverage may be used to reduce a pre-existing condition limitation period, provided the prior coverage was continuous (provided any break in coverage did not exceed 62 days).

Deductible

The amount a subscriber must pay each year toward covered expenses before the insurance plan begins paying.

Deferred Effective Date

A delayed effective date for insurance coverage, applicable to an employee who is absent from work due to injury or sickness on the date coverage would otherwise have become effective. The effective date is then deferred until the individual returns to work as active, permanent, full-time employee for one full day.

Dentist

A dentist or physician licensed in the jurisdiction where services are performed and practicing within the scope of his license.

Dependent Child

An unmarried child under 19 years of age (or under age 25 if a full-time student) and who is principally dependent upon the subscriber for maintenance and support, provided the child is: (1) the natural or adopted child, stepchild, foster child or child for whom the subscriber has legal custody and who resides in the subscriber's home in a parent-child relationship; or (2) for whom the subscriber provides support and maintenance due to a court order. See also *Full-time Student* and *Incapacitated Child*.

Dependent Spouse

A lawful spouse of a subscriber, or former spouse required to be covered by a divorce decree or court order, but not both. If a spouse is also eligible for coverage or benefits as an employee of a state-covered entity, the spouse may not be covered as a dependent. However, a part-time teacher who is the

spouse of a covered employee who is a state employee may be covered as either an employee or as a dependent, but not both.

Durable Medical Equipment

Prescribed medical equipment (i.e., wheelchair, respirator) that can be used for an extended period of time.

Employee

An employee is a person employed by the state, a school district or a participating local subdivision who must be working at least 30 hours a week in a position classified by the employer as permanent and full-time, and who receives compensation from a department, agency, board, commission or institution of the state, a school district or a participating local subdivision. This includes clerical and administrative employees of the S.C. General Assembly and judges in the state courts. S.C. General Assembly members and elected members of participating county or municipality councils who participate in the South Carolina Retirement Systems (SCRS) also are considered employees for insurance purposes. Permanent, part-time teachers are also considered employees for insurance purposes.

EIP

The Employee Insurance Program.

Enrollment Date

(1) The hire date for an employee; (2) the effective date of coverage for an individual who enrolls under a special eligibility situation and for a late entrant; and (3) the retirement date for a retiree.

Exclusion

A specific condition or circumstance for which an insurance plan or policy will not provide benefits.

Extended Care Benefits

Benefits that provide for medical care in a more cost-effective setting when hospitalization is not required or necessary. Extended care benefits

include home health care, skilled nursing facility care, hospice care and alternative treatment plans.

Fee-For-Service Plan

A type of health or dental plan that operates on a fee-for-service basis. Subscribers may use the services of any provider under this type of plan and may change their choice of service provider at any time without approval from the plan. See also *Indemnity Plan*.

Full-Time Student

An unmarried child who is 19 years of age but less than 25 years of age who is enrolled in and attending a high school, trade, vocational or technical school or college (not correspondence courses) on a full-time basis as defined by the institution.

Health Maintenance Organization

A managed care plan that has contractual arrangements with healthcare providers (doctors, hospitals, etc.) who together form a provider network. HMO subscribers are required to see only providers within this network. If a subscriber receives care outside of this network, the HMO will not pay benefits for these services unless the care was pre-authorized or deemed an emergency. Subscribers choose a primary care physician (PCP) who coordinates all aspects of the subscriber's healthcare. To receive benefits, subscribers must receive a referral from their PCP before they can see a specialist.

HMO

See *Health Maintenance Organization*.

Home Health Care

Part-time nursing care; health aide service; or physical, occupational or speech therapy provided by an approved home health care agency and given in the subscriber's home. These services do not include custodial care or care given by a person who ordinarily lives in the home or a member of the subscriber's family or the spouse's family.

Hospital

A legally designated and operated institution caring for the sick, such as a general hospital; children's hospital; eye, ear, nose and throat hospital; maternity hospital or an ambulatory surgical center. "Hospital" also includes a legally constituted and operational psychiatric facility for the treatment of mental or nervous conditions or substance abuse. Hospitals must provide inpatient care given by, or supervised by, a staff of licensed physicians and must provide continuous 24-hour services by licensed registered nurses who are physically present and on duty. Nursing homes, rest homes, homes for the aged and convalescent homes are typically not considered hospitals under insurance plans, whether or not they are affiliated with a hospital.

Identification Number

For most plans, typically the covered person's Social Security number. Identification cards are issued by the insurance plan. Note for retirees: Under the State Health Plan Economy, Standard or Medicare Supplemental plan, the retiree's Social Security number is used for all covered family members. Use the number listed on the Medicare card for Medicare claims and information. Note for survivors: For surviving spouses and surviving spouses with covered children, the surviving spouse's Social Security number is used for all covered family members. For surviving children only, the youngest child's Social Security number is used.

Incapacitated Child

An unmarried child who is incapable of self-sustaining employment because of mental illness or physical handicap and is principally dependent on the subscriber for maintenance and support. Incapacitation must have begun before age 19 or while an eligible covered dependent, full-time student. If eligible but not previously covered, the child may not be added until the next open enrollment period (or within 31 days of a special eligibility situation),

and coverage is subject to pre-existing condition limitations.

Indemnity Plan

A type of health or dental plan that operates on a fee-for-service basis. Subscribers may use the services of any physician or dentist under this type of plan and may change their choice of service provider at any time without approval from the plan. See also *Fee-for-Service Plan*.

Incurred Expense

An expense is considered incurred on the date services were rendered or supplies were received.

Injury

An accidental bodily injury that requires treatment by a physician. Any loss that results from the injury must be independent of sickness or other causes.

Inpatient

A person who has been admitted at least overnight to a hospital or other health facility for the purpose of receiving diagnostic/medical treatment or services.

Late Entrant

A full-time employee or eligible retiree, and any eligible dependent of that employee or retiree, who is not enrolled within 31 days of that person's first date of eligibility and who subsequently enrolls during an open enrollment period. A late entrant is subject to the pre-existing condition exclusion for 18 months after coverage begins.

Local Subdivision

Any participating entity covered by local jurisdiction rather than state. Examples of local subdivisions include: counties, councils on aging, commissions on alcohol and other drug abuse, special purpose districts, community action agencies, disabilities and special needs boards, municipalities, recreation districts, hospital districts and councils of government.

Managed Care

Ways to manage costs and use of the health care system (i.e., provider networks, fee-for-service agreements and health education). HMOs, POS plans and many fee-for-service plans have managed care.

Maximum Coinsurance

See *Coinsurance Maximum*.

Maximum Copayment

See *Copayment Maximum*.

Maximum Out-of-Pocket

See *Out-of-Pocket Maximum*.

Medi-Call

Medi-Call is the utilization review program for State Health Plan subscribers. Medi-Call ensures they receive appropriate medical care in the most beneficial, cost-effective manner. Note: Retirees and dependents entitled to Medicare must call Medi-Call for home health care, hospice, durable medical equipment, Veterans Administration hospital services and when the number of hospital days allowed by Medicare is exceeded.

Medically Necessary

Services or supplies ordered by a physician or mental health care provider to identify or treat an illness or injury. Services and supplies must be given in accordance with proper medical practice prevailing in the medical specialty or field at the time the patient receives the service and in the least costly setting required for the patient's condition. The service must be consistent with the patient's illness, injury or condition and be required for reasons other than the patient's convenience. The fact that a physician prescribes a service or supply does not necessarily mean it is medically necessary.

Medicare Supplemental Plan

A health plan offered to retirees and their dependents who are entitled to Medicare. As a "supplemental" plan, it generally pays the deductibles and

coinsurance amounts for approved services that Medicare does not.

Mental Health and Substance Abuse Provider

A licensed psychiatrist, counseling or clinical psychologist, psychiatric clinical nurse specialist, licensed professional counselor, licensed marital and family therapist or licensed independent social worker who is acting within the scope of the license.

Non-Assigned Claim

A claim for which the provider does not accept Medicare's allowable charge for a covered expense. Instead the provider may charge more, and the subscriber must pay the difference.

Notice of Election Form

The Notice of Election (NOE) form is the application form used to enroll in benefits; add or delete dependents; or change coverage level, beneficiary, name or address.

Open Enrollment

A period during which eligible employees, retirees, survivors and COBRA subscribers may enroll in or drop their own coverage and add or drop eligible dependents to/from a health plan without regard to any special eligibility situations. Retirees may also change to and from the Medicare Supplemental program during an open enrollment period. An open enrollment period is held in October of years ending in an odd number. Enrollment changes become effective the following January 1.

Out-Of-Pocket Maximum

The most money a covered person will be required to pay a year for deductibles and coinsurance. The amount is set by the insurance plan.

Outpatient

A patient who receives ambulatory care at a hospital or other facility without being admitted to the facility, such as overnight.

Part-Time Teachers

Teachers who are permanent and work at least 15 hours but no more than 29 hours per week at a South Carolina public school, the South Carolina Department of Juvenile Justice or the South Carolina Department of Corrections are eligible for the state health, dental, MoneyPlu\$ and vision care programs. They must also be in a contract position and receive an EIA salary supplement. Premiums are determined by the number of hours an eligible part-time teacher works per week.

“Pay-the-Difference” Policy

If a generic drug is available and a subscriber chooses to purchase the brand name medication instead, the benefit will be limited to the cost of the generic medication; the subscriber will be responsible for the difference in price between the brand name drug and the generic drug plus the generic copayment amount. This difference in price does not apply toward the subscriber’s copayment maximum.

Per-Occurrence Deductible

The amount a covered person must pay each time there’s an emergency room, inpatient or outpatient hospital visit before the health plan begins to pay benefits.

Physician

A licensed medical doctor, dentist, oral surgeon, podiatrist, osteopath, chiropractor, psychiatrist or licensed counseling or clinical psychologist.

Plan

The State Health Plan or the State Dental Plan.

Plan Year

January 1 through December 31 (calendar year).

Point of Service

A managed care plan that not only allows subscribers to choose to use providers or specialist within the plan’s network as referred by their primary care physician, but also allows subscribers can self-refer to a provider outside the network. To receive the

highest level of benefits, subscribers must use participating providers. Out-of-network services are allowed; however, benefits are paid at a reduced level.

POS

See *Point of Service*.

PPO

See *Preferred Provider Organization*.

Pre-Existing Condition

Any medical condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received by a licensed health care provider or practitioner in the six months preceding the covered person’s enrollment date. Benefits for a pre-existing condition are payable only for treatment provided at least 12 months (18 months for a late entrant) after the enrollment date. Pregnancy does not constitute a pre-existing condition. See also *Creditable Coverage*.

Preferred Provider Organization

A PPO is a type of health or dental plan that is similar to a fee-for-service plan. A PPO has arrangements with doctors, hospitals and other providers who have agreed to accept the plan’s allowable charges for covered medical services as payment in full and will not balance bill you. Participating providers also file claims for you.

Premium

The amount a covered person pays in exchange for insurance coverage.

Prescription Drug

Any drug or medicine required to bear the following wording, “Caution: Federal law prohibits dispensing without prescription.” Insulin or drugs licensed or accepted for a specific diagnosis as listed in the U.S. Pharmacopeia Publication, *Drug Information for Health Care Professionals*, are also considered prescription drugs. Drugs in FDA phase I, II or III testing are not covered.

Primary Care Physician/Doctor

Usually the first contact for health care, this is often a family physician, internist, or in some cases, a gynecologist. A primary care physician monitors the patient's health and diagnoses, treats minor health problems and refers the patient to specialists if another level of care is necessary.

Private Duty Nursing Services

Private services of a registered nurse or licensed practical nurse. Services must be certified in writing by a physician as medically necessary.

Provider

Any person (i.e., doctor, nurse, dentist) or facility (i.e., hospital or clinic) that provides medical care.

Qualifying Event

In general, an event that allows insurance coverage or an extension of insurance coverage for an employee, spouse or dependent. Such events may be marriage, birth/adoption/placement, loss of group health plan coverage, divorce/legal separation, death of the covered employee, loss of dependent's eligibility for coverage, etc.

SHP

See *State Health Plan*.

Sickness

A disease, disorder or condition that requires treatment by a physician.

Significant Break in Coverage

A period of 63 or more consecutive days during which an individual does not have any creditable insurance coverage. Neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. See also *Creditable Coverage*.

Skilled Care

Services provided according to a physician's order, given by or under the direction of a qualified technical or professional health care provider. Health care

providers include registered nurses, licensed practical nurses, physical therapists, speech pathologists and audiologists.

Special Eligibility Situation

A qualifying event that allows eligible employees, retirees, survivors or COBRA subscribers to enroll themselves and/or their eligible dependents in an insurance plan. Examples include: marriage, birth, adoption or placement. Involuntary loss of other coverage applies only to those who lost coverage. Enrollment changes must be requested within 31 days of the qualifying event. Note: A salary increase does not constitute a special eligibility situation. See also *Qualifying Event*.

Spouse

See *Dependent Spouse*.

State-Covered Entity

A state agency, public school district, county, municipality or other group participating in the Plan.

State Health Plan

The term used generally to identify the Economy, Standard, and Medicare Supplemental plans.

TERI

Teacher and Employee Retention Incentive program of the South Carolina Retirement Systems.

Transfer/Transferring Employee

An active employee who changes employment from one state group entity to another with no more than a 15-calendar-day break in employment or in insurance coverage. An academic employee who completes a school term and moves to another academic setting at the beginning of the next school term is also considered a transferring employee. A transferring employee is not considered a new hire for insurance program purposes.

You

Any person who is insured under the policy. You and/or your covered dependents.

Index

Monthly Premiums

2003 COBRA Dental Plan Monthly Premiums 54
2003 COBRA Health Plan Monthly Premiums 54
2003 Long Term Care Insurance Premiums 56, 57
2003 Optional Life Insurance Portability Premiums 55
2003 Regular Retiree (Employer-Funded Benefits) Dental Plan Monthly Premiums 51
2003 Regular Retiree (Employer-Funded Benefits) Health Plan Monthly Premiums 51
2003 Retiree (5-10 year, buy-in & age 55/25 year) Dental Plan Monthly Premiums 52
2003 Retiree (5-10 year, buy-in & age 55/25 year) Health Plan Monthly Premiums 52
2003 Survivor Dental Plan Monthly Premiums 53
2003 Survivor Health Plan Monthly Premiums 53

A

About Medicare 12
Accidental Death and Dismemberment 44
Active employee 2, 8, 12, 20, 22, 28, 30, 46, 48, 49
Actively at work G-1
Activities of daily living 46
Adding/Changing Coverage 10
Adoption 10
Adult daycare 46
Advantages of the Long Term Care Program 46
Aetna 47, 58
Allowable charge G-1
Alternative health care 6
Ambulance 34, 38
Ambulatory surgical center 19

Ambulatory Surgical Center Network 21, 27
Annual deductibles 32, 36
Annual enrollment G-1
APS Healthcare, Inc. 15, 16, 20, 21, 22, 26, 27, 58
Assigned claim G-1
Assignment. *See* Medicare assignment
At Age 65 12

B

Balance billing G-1
Balanced Budget Act 12
Basic Life Insurance 43, 49
Basic Long Term Disability 1, 2, 45, 49
Basic salary G-1
Beneficiary, beneficiaries 43, 46
Benefit credit 17
Benefit period 19, 24, 25
Birth 10
BlueCard Program 20, 26
BlueCard Worldwide 26
BlueCross BlueShield of South Carolina 9, 15, 16, 20, 26, 58
Breast exam 22, 27
Buy-in 3, 52

C

Cancellation policies 32, 36
Carve-out 13, 14, 15, 19, 20, 28, 36, 38
Carve-out method of claims payment 14, 36, 38
Changes You May Make Throughout the Year 10
Changing plans G-1
Child, children 3, 4, 6, 8, 10, 22, 27, 33, 53
Chiropractic 6
Choosing a Health Plan in Retirement 5-7
CIGNA HealthCare 9, 17, 58
CIGNA HMO 6, 17, 18, 29, 32, 34, 37, 39, 51, 52, 53, 54

CIGNA POS 6, 17, 18, 29, 33, 35, 37, 39, 51, 52, 53, 54
Claim, claims 8, 14, 16, 22, 28, 30
Claims Filed Inside South Carolina 28
COBRA 2, 4, 8, 29, 41, 54, G-1
Coinsurance 15, 16, 17, 19, 22, 24, 25, 27, 32, 33, 34, 35, 36, 37, 38, G-1
Coinsurance maximum 15, 32, 34, 35, 36, G-2
Companion HealthCare 9, 16, 17, 58
Companion HMO 6, 16, 29, 32, 34, 35, 37, 39, 51, 52, 53, 54
Companion-CHOICES 6, 16, 29, 33, 35, 37, 39, 51, 52, 53, 54
Comparison of Health Plan Benefits for Those Entitled to Medicare 36
Comparison of Health Plan Benefits for Those NOT Entitled to Medicare 33
Consolidated Omnibus Budget Reconciliation Act. *See* COBRA
Contacts 34, 39
Continued stay authorization 27
Continuing Coverage Into Retirement 47
Convalescent 47
Coordination of benefits 13, 14, 17, G-2
Copayment G-2
Copayment, copayments 7, 29, 33
Copayment maximum 21, 36, G-2
Course of treatment 41
Covered expense, expenses 20, G-2
Covered person G-2
Covering Dependents 8
Creditable coverage G-2
Custodial care 46

D

Death 10
Deciding on Coverage 49
Decreasing Coverage 10
Deductible, deductibles
 7, 14, 15, 16, 17, 19, 22, 24,
 25, 26, 27, 29, 32, 33, 35,
 36, 37, 38, 39, G-2
Deductibles and Coinsurance
 15, 19
Deferred effective date G-2
Dental benefits 40
Dental Plus 9, 40, 42
Dentist G-2
Dependent Care Spending Account
 48
Dependent child G-2
Dependent, dependents
 3, 5, 6, 8, 10, 13, 19, 29, 41,
 44, 53
Dependent Life Insurance 44, 49
Dependent Spouse G-2
Determine Your Need for Long
 Term Care Insurance 46
Dialysis 19, 20
Disability
 2, 7, 8, 13, 43, 44, 45, 50
Divorce 10
Durable medical equipment
 19, 20, 25, 26, 34, 38, G-3

E

Earnings limitation 49, 50
Economy plan
 5, 9, 13, 19, 32, 34, 51, 52, 53, 54
EIP
 8, 9, 10, 13, 19, 23, 28, 29,
 40, 41, 42, 43, 44, 47, 50,
 G-3. *See also* Employee Insur-
 ance Program
Eligibility for Employer-Funded
 Insurance 2
Eligibility for Non-Employer-
 Funded Insurance 2
Eligibility for Survivors 3
Emergency 29
Emergency room 6, 19
Employee G-3
Employee Insurance Program
 1, 3, 13, 19, 29, 40, 43, 45, 47,

50, 58. *See also* EIP
Enroll, Enrollment
 3, 8, 10, 16, 19, 21, 24, 25, 29,
 47, 49
Enrolling in Coverage at Retirement
 47
Enrolling In or Making Changes to
 Coverage 8–11
Enrollment date G-3
Exclusion G-3
Explanation of benefits 28
Explanation of Medicare Benefits
 14, 16, 22, 23, 28
Extended care benefits G-3
Eyeglasses 34, 38

F

Fee-for-service plan G-3
Filing Claims As a Retiree
 22, 28, 30
Filing Dental Claims 41
Filing Dental Plus Claims 42
Fringe Benefits Management Com-
 pany 58
Full-time student 10, G-3

G

General Assembly Retirement
 System 3
General Information Regarding the
 Standard and Economy Plans 19
Glossary of Terms G-1
Government nursing facilities 47
Group Life Insurance 50

H

Harrington Benefit Services, Inc.
 9, 59
Health maintenance organization
 5, 12, 13, 17, 29, 48,
 G-3. *See also* HMO
Hearing aid 34, 38
HMO
 9, 12, 13, 16, 17, 18, 29, 30, 33,
 34, 35, 37, 39, G-3. *See also*
 Health maintenance organiza-
 tion
HMO and POS Available Areas of
 Service in South Carolina 6
HMO and POS Plans in Retirement
 29–30

Home health 6, 12
Home health care
 19, 20, 25, 26, 34, 38, 46, 47,
 G-3
Hospice
 6, 12, 19, 20, 26, 34, 38, 47
Hospital G-4
Hospital Admissions 24
Hospital network 20
How Medicare Assignment Works 13
How TERI Affects Your Insurance
 Coverage 50
How TERI Works 49
How the HMO and POS Plans Work
 Together With Medicare 16
How the Medicare Supplemental
 Plan Works Together With
 Medicare 15
How the State Health Plan's Stan-
 dard Plan Works Together With
 Medicare 14

I

Identification 9, 22, 28, 41
Identification card 20, 29
Identification number G-4
If Medicare Denies Your Claim
 23, 28
If You Are Entitled to Medicare 49
If You DO Choose the Medicare
 Supplemental Plan 16
If You DO NOT Choose the
 Medicare Supplemental Plan 16
If You Exceed the Number of
 Inpatient Hospital Days Al-
 lowed Under Medicare 20, 26
Immunizations 22, 27, 33, 36
Incapacitated child, children 4, 9
 G-4
Incurred expense G-4
Indemnity plan G-4
Injury G-4
Inpatient 12, 19, 20, 21, 24, 26,
 27, 32, 33, 34, 36, 37,
 38, G-4
Insurance Benefits Guide
 1, 15, 16, 17, 19, 20, 21, 22, 24,
 27, 29, 40, 42, 43, 44, 46
Introduction 1

J

Judges-Solicitors Retirement System 3

L

Late entrant 3, 8, G-4
Licensed practical nurse 25
Life Insurance in Retirement 43–44
Lifetime maximum benefits 32, 36
Local subdivision G-4
Local subdivisions 2, 9, 47, 51, 52
Long Term Care 9, 10, 46, 47
Long Term Care in Retirement 46–47
Long Term Care Services Already Covered 46
Long Term Disability 8

M

Making a (health plan) Decision 6
Mammograms 22, 27. *See also*
Mammography
Mammography 34, 38. *See also*
Mammograms
Mammography Testing Benefit 22, 27
Managed care G-5
Marriage 10
Maternity 19
Maternity Management Benefit 22, 27
Medco Health Solutions, Inc. 21, 26, 59
Medi-Call 19, 20, 21, 22, 25, 26, 27, 32, 33, 34, 36, 38, 58, G-5
Medicaid 46
Medical evidence of good health 10, 44, 47
Medical Spending Account 48
Medically necessary 25, 33, 37, G-5
Medicare 5, 6, 7, 9, 10, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 36, 38, 46, 49, 51, 52, 53, 59
Medicare + Choice 12
Medicare and the Ambulatory Surgical Center Network 21, 27
Medicare and the SHP Hospital Network 20, 26

Medicare and Transplant Contracting Arrangements 21, 27
Medicare and Using Medi-Call 26
Medicare assignment 13, 15, 17, 22, 24
Medicare Deductibles and Coinsurance 24
Medicare Supplemental plan 5, 7, 9, 10, 13, 15, 19, 24, 25, 26, 27, 28, 36, 38, 51, 52, 53, G-5
Medicare Supplemental Plan Deductibles and Coinsurance 24
Medigap 24
Mental health and substance abuse 6, 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, 32, 36
Mental health and substance abuse provider G-5
Mental Health and Substance Abuse: When to Call APS 27
Military retiree 13
MoneyPlu\$ 44, 48, 49
MoneyPlu\$ Not Available in Retirement 48
MUSC Options 5, 6, 9, 29, 33, 51, 52, 53, 54, 59

N

NOE 8, 10, 13, 41, 42. *See also*
Notice of Election
Non-assigned claim G-5
Notice of Election 8, 41, 42, 50. G-5. *See also* NOE
Nursing home 6, 46

O

Occupational therapists 12
Oncology 19, 20
Open enrollment 8, 10, 11, 16, 41, G-5
Ophthalmologists 48
Opticians 48
Optional Life Insurance 43, 49
Optometrists 48
Orthodontia 42
Out-of-pocket expenses 19
Out-of-pocket maximum G-5

Outpatient 12, 19, 20, 21, 24, 25, 27, 33, 36, 37, G-5

P

Pap test 22, 23, 27, 28, 34, 38
Pap Test Benefit 22, 27
Part-time teacher G-6
Pelvic exam 22
Per-occurrence deductible 32, 36, G-6
Pharmacy networks 19
Physical therapists 12
Physical therapy 6, 19, 20
Physician G-6
Physician Charges 25
Physician network 20
Physician visits 32, 36
Plan G-6
Plan year G-6
Point of Service 5, 12, 13, 17, 29, 33, 35, 37, 39, G-6. *See also* POS
Police Officers Retirement System 3
POS 5, 13, 16, 17, 18, 29, 30, 33, 35, 37, 39, G-6. *See also* Point of Service
Power of attorney 11
PPO 38. *See also* Preferred provider organization
Pre-existing 8, 12, 47
Pre-existing condition G-6
Precertification 21, 22, 27, 41
Predetermination of Benefits 41
Preferred provider organization 12, 33, 34, G-6
Premium G-6
Premium, premiums 2, 3, 7, 9, 10, 11, 12, 19, 24, 33, 36, 40, 42, 43, 44, 46, 47, 51, 52, 53, 54
Premiums in Retirement 47
Prenatal 22
Prescription Drug Program 21, 26, 29
Prescription drug, drugs 6, 18, 21, 26, 32, 36, G-6
Primary care physician 7, 29, 33, 37, G-7

Private duty nursing
16, 18, 20, 21, 24, 25, 26, 34,
38, G-7
Prosthetic lenses 34, 38
Provider G-7
Provider Networks 29
Provider sponsored organizations
12

Q

Qualifying event 4, 8, 41, G-7

R

Railroad Retirement Board 23, 28
Railroad Retirement Claims 23, 28
Registered nurse 25
Remarriage 4
Retired employees 44
Retiree Group Life Insurance 43
Retiree Insurance Eligibility 2–4
Retiree Outreach Services 50
Retiree Premiums/Premium Pay-
ment 9
Retirement and Long Term Disabil-
ity 45
Retirement annuity 45
Returning to Work 49
RRB. *See* Railroad Retirement Board

S

Schedule of Dental Procedures and
Allowable Charge 40
School districts 9
SCRS 1, 2, 3, 9, 47, 50. *See also*
South Carolina Retirement
Systems
Separation 10
Service area, areas
5, 13, 18, 29, 32, 36
Service credit 2, 3, 43, 50
SHP
15, 16, 19, 20, 21, 22, 23, 24, 26,
27, 28, 34, 38, G-7. *See also*
State Health Plan
Sickness G-7
Significant break in coverage G-7
Skilled care G-7
Skilled nursing
12, 15, 16, 19, 20, 26, 34, 38, 46
Skilled nursing facility, facilities
15, 16, 24, 25

Social Security 8, 9, 12, 49. *See also*
Social Security Administration
Social Security Administration
5, 12, 59. *See also* Social Security
Social Security number 9
South Carolina Retirement Systems
1, 2, 9, 43, 49, 59. *See also*
SCRS
Special eligibility situation
3, 8, 10, 41, G-7
Spouse, spouses
3, 8, 10, 12, 13, 22, 27, 46, 47, 53
Standard Insurance Co. 59
Standard plan
5, 9, 13, 14, 16, 19, 20, 21, 32,
34, 36, 38, 51, 52, 53, 54
State agencies 9
State Dental Plan 9, 40, 42
State Dental Plan Covered Services
40
State Health Plan
5, 6, 7, 9, 13, 14, 16, 18, 19, 24,
46, 47, 48, G-7. *See also* SHP
State Health Plan Prevention Part-
ners 59
State-covered entity G-7
Student, students 4, 8, 10
Supplemental Long Term Disability
1, 2, 45, 49

T

Teacher and Employee Retention
Incentive 49. *See also* TERI
TERI 2, 8, 49, 50, G-7. *See also*
Teacher and Employee Reten-
tion Incentive
Terminating or Cancelling Coverage
11
The Hartford 43, 44, 59
The Medicare Supplemental plan
24–28
The State Health Plan in Retirement
19–23
Tips on Choosing a Plan 18
Transfer G-7
Transferring employee G-7
Transplant 19, 21, 27
TRICARE 13, 59

U

Using Medi-Call as a Retiree 20

Utilization review 20, 26

V

Veterans Administration 20, 26
Vision care 6
Vision Care Program 34, 38, 48
Vision Care Program in Retirement
48

W

Well child care 6, 33, 36
Well Child Care Benefit 22, 27
What Long Term Care Does Not
Pay 47
What Long Term Care Pays 46
What the Medicare Supplemental
Plan Covers 24
When Long Term Care Pays 46
When Traveling Outside of South
Carolina 21
When Traveling Outside the Net-
work or the United States 26,
29
When You Or Your Dependents
Become Entitled to Medicare
12
When Your Coverage as a Retiree
Begins 9
Where To Go for More Information
Regarding Medicare 12
Who to Contact for More Informa-
tion 58
Workers' Compensation 47

Y

You G-7
Your Dental Benefits in Retirement
40–42
Your Health Plan Choices 5
Your Insurance Identification Card
in Retirement 9
Your Plan Choices 13

Notes

Total printing costs: \$
Total number printed:
Unit cost: \$